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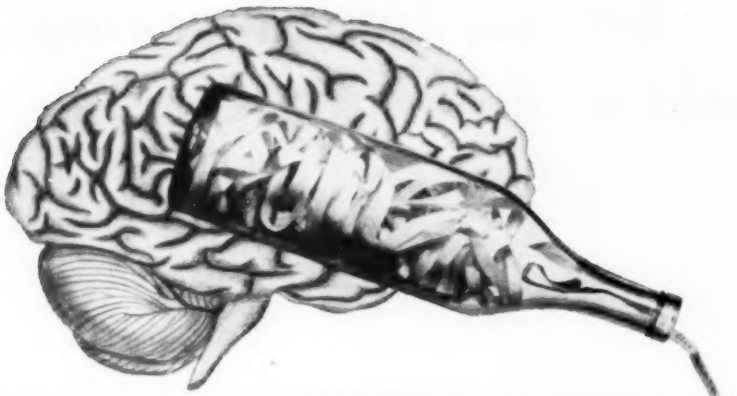

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Levine, J., Rinkel, M. and Greenblatt, M.: Am. J. Psychiat., 105:429, 1948.

Shorvon, H. J., Rook, A. J. and Wilkinson, D. S.: Brit. M. J., 1300, Dec. 1950.

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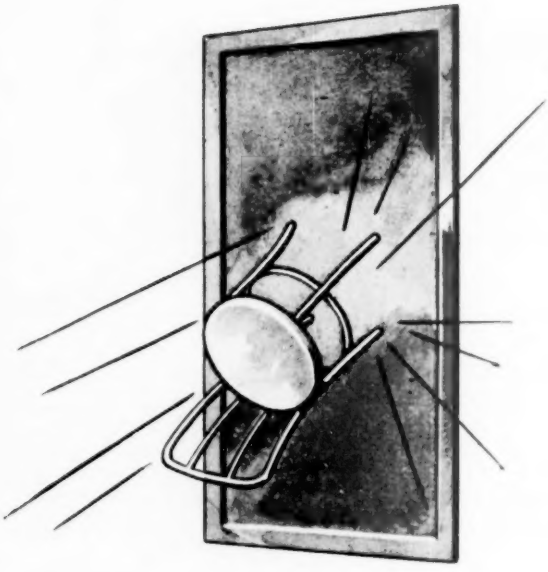

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In the drug therapy of the epileptic, nothing short of *complete* suppression of seizures can rightly be called full success. Complete seizure-control is a prerequisite to the patient's return to a normally active life. Carter[1] states: "Basically all efforts should be directed toward preventing seizures and the tendency to chronic invalidism."

The management regimen should include:[1]

I. Good physical and mental hygiene.
   a) Wholesome diet; Regular bowel habits; Avoid noxious materials, e.g. alcoholics; Moderate physical activity.
   b) Help overcome feeling that epilepsy is shameful; Encourage normal work and recreation; Regular sleep without overprotection.

II. Anticonvulsant medication selected on the basis of Exact Diagnosis:
   "Certain drugs are more effective in one type of seizure than they are in another, and it is necessary to use proper drugs. The dosage must be individualized for each case."[1]

Thus, the best guide in selecting medication for a patient is the type of seizures present. (Frequently several drugs in combination is most effective.)

The table shows which drugs are indicated for each type of seizure. It will be noted that the newer hydantoin, Mesantoin, is effective for *grand mal*, Jacksonian and focal seizures.

MESANTOIN DOSAGE is adjusted to the lowest level adequate to attain freedom from seizures. Start with ½ or 1 tablet daily during the first week; increase the daily intake by ½ or 1 tablet during the next week. Continue this up to optimal dosage. When another drug has not given good results, Mesantoin is added by the same procedure; then the old drug is gradually reduced.

SIDE EFFECTS — Mesantoin produces side effects in some cases: Skin and blood changes are signs of sensitivity — the drug should be discontinued. Drowsiness develops upon reaching maximum dosage.

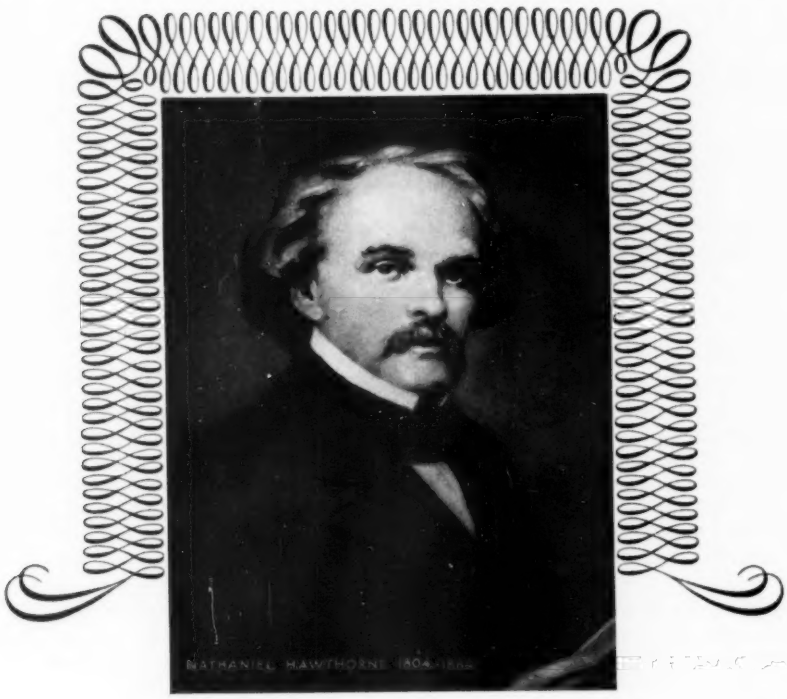
PRECAUTIONS — Certain precautions are necessary to minimize untoward effects.

a. close check on patient — repeated visits and blood counts.
b. No Mesantoin, if white cell count below 4000.
c caution if (1) rash or blood changes.
   (2) History of drug sensitivity.
d. discontinue drug if (1) bleeding of gums or vagina.
   (2) Sore throat

TYPE OF EPILEPSY	PRIMARY CLINICAL MANIFESTATIONS	MEDICATION	AVERAGE ADULT DAILY DOSE★	LIMITING SIDE EFFECTS	SIGNS OF SENSITIVITY
GRAND MAL	Aura followed by loss of consciousness; tonic-clonic convulsions and autonomic disturbance, e.g., in bladder function.	Phenobarbital	1½ grs. h.s. Usual max.: 3 grs. per day	Sleepiness	
		5,5 diphenyl hydantoin	1½ grs. t.i.d., p.c. Usual max. 6 grs. per day	Diplopia, staggering (may increase petit mal)	Overgrowth of gums, body hairs; itching rash on extremities, gastric irritation
JACKSONIAN	Convulsions begin in one area and spread outwards (Jacksonian march.). No loss of consciousness.[3]	3 methyl 5,5 phenylethyl hydantoin (mesantoin)	Adults: 2 to 6 tabs. Children: 1 to 4 tabs.	Sleepiness	Full details given; see Psychomotor cross-column below
		phenylacetylurea[3]	2 Gms. per day. Max. dose 6 Gms. per day[4]	Drowsiness[3]	Central nervous system affected, nausea, vomiting and abdominal pain[3]
PSYCHOMOTOR	Period of amnesia; actions apparently purposeful but mechanical; incoordination. Mild tonic spasms. In children: "behavior problems".[2]	3 methyl 5,5 phenylethyl hydantoin[4]	Adults: 2-6 tabs. Children: 1-4 tabs.	Pharyngitis, mucous membrane bleeding, lymphadenopathy, measles-like rash with itching and fever; in severe reaction: blood dyscrasia.	
		phenylacetylurea[3]	See phenylacetylurea—above		
PETIT MAL TRIAD	Attacks: in series (rapid succession), abrupt onset, few sec. duration; no aura nor impairment of consciousness. Rhythmic twitching (e.g. eyelids).	3,5,5 trimethyl oxazolidine 2,4 dione	0.9 to 1.2 Gms.	Inability to see in a bright light. Drowsiness	Hiccough, acneform rash, leukopenia
		N methyl derivative of phenobarbital	6 grs.	Sleepiness	

★Although an average daily dose can be stated for each of these drugs, to obtain best results it is necessary that the physician determine the dose required by each individual patient for maximum control of his seizures.

Bibliography: 1. Carter, S., in Conn, H.: Current Therapy 1949. Phila., Saunders Co., p. 495. 2. Kaufman, I.: Dis. Nerv. System 11: 99, 1950. 3. Lennox W.: Science & Seizures, ed. 2, N.Y.C., Harper & Bros., 1946. 4. Harris, T. & Otto, J.: Texas J. Med. 43: 328, 1947. 5. Little S. & McBryde, R.: Am. J. M. Sc. 219: 494, 1950. (Except as otherwise indicated, the data tabulated is from: Gibbs, F.: Ann. Int. Med. 27: 548, 1947.)



Psychoneurotics of Genius

Hawthorne, distinguished American novelist, is said to have been afflicted with a psychoneurosis from early childhood. His quiet life, wholly detached from the major activities of the times, was largely given over to brooding solitude.

The majority of psychoneurotics have no serious mental illness, but display merely an emotional imbalance which often can be greatly improved by appropriate psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is especially useful when tranquillity with minimal hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily. Children, from 16 to 32 mg. (¼ to ½ grain) three or four times daily. Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

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A CRITICISM OF THE TERMS "PSYCHOSIS," "PSYCHONEUROSIS," AND "NEUROSIS"[1]

KARL M. BOWMAN, M.D., AND MILTON ROSE, M.D.
San Francisco, Calif.

Two of the most fundamental and widely used terms in psychiatry are "psychosis" and "psychoneurosis" or "neurosis." We venture to say that there is not a psychiatrist in this audience who does not frequently ask himself or his associates, "Is this a case of psychosis or of neurosis?" The meanings of these terms may at first seem obvious and hardly in need of clarification at this late date in their usage. A quick perusal of psychiatric literature, however, offers ample evidence that there is a great deal of confusion both practically and theoretically in defining and applying these terms. We feel, therefore, that with the radical revision of psychiatric nomenclature which is to appear in the next issue of the Standard Nomenclature of Diseases a review of the use of the terms "psychosis" "psychoneurosis," and "neurosis" and an analysis of the reasons for confusion in current usage is timely and in the interest of clear thinking in psychiatry.

There is so much variation in meaning in the common usage of these terms that it is next to impossible to make common usage the basis for defining "psychosis" and "neurosis" for purposes of classification. We hear the two distinguished on the basis of different etiologies, of different descriptive clinical pictures, of different prognosis, of quantitative differences in symptomatology, and of qualitative differences in symptomatology. Sometimes the distinction is made by dividing psychiatric disorders into "major reactions" involving the whole personality and "minor reactions" involving only a part of the personality. The terms are frequently used to refer to legal and social differences—the psychoses are considered to be hospital cases ordinarily committable, in contradistinction to the neuroses, which are considered to be mostly ambulatory, treatable in private practice or on an outpatient basis, and not legally committable. "Psychosis" is very often used as synonymous with the term "schizophrenia."

The reasons for variation in the use of the basic terms in psychiatric classification are to be found partly in the origin and historical development of the use of the terms and partly in the fundamental problems of scientific method and psychiatric classification. The purpose of this paper is to try to clarify some of the problems involved in the development of past and present psychiatric nomenclature, with special reference to the use of "psychosis" and "psychoneurosis" or "neurosis" as diagnostic classifications. Our procedure will be, first, to summarize briefly the origin and historical development of the terms and, second, to examine the relationship between the present status of psychiatric understanding of mental illness and the recent revision of the official system of nomenclature.

Those disorders that we know as "mental illnesses" were brought into the domain of medicine during the eighteenth century. Physicians for the most part believed that "mental" illnesses were really physical illnesses, that is, neurological disorders. Late in the eighteenth century, William Cullen introduced the term "neuroses" to designate the functional diseases of the nervous system as they were being studied by neuropathology, at that time in the infant stage as a branch of medicine(1). During the nineteenth century, the major work in psychiatric nosology was done by German psychiatrists, whose study of mental disorders we might call psychobiological in the sense that mental illnesses were believed to be specific disease entities involving both the physiological and the psychological aspects of the human organism. The term "psychosis" was introduced in 1845 by one of these Germans, Feuchtersleben, to refer to the psychological manifestations of a mental disorder in

[1] Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

contradistinction to the underlying physiological condition(2). The illness itself was still called a "neurosis," a nervous disease. In keeping with the tradition of clinical medicine, the important problem was held to be the gathering of descriptive data, physiological and psychological, about these disease entities, and the developing of classifications based upon symptomatology.

The culmination of nineteenth century development of psychiatric clinical description and terminology was reached in the system of Emil Kraepelin, which laid down what have been the classical divisions of all subsequent psychiatric nosologies, especially the distinction made between constitutional psychopathic inferiority, psychoneuroses, and the various psychoses. The success and continued influence of Kraepelin's classification are undoubtedly due to the fact that he assembled detailed observations and grouped them in a way that proved clinically valid and useful, even though his use of prognosis as a determinant of diagnosis was unscientific and often an obstacle to dealing helpfully with patients.

Parallel with the development of this clinical, descriptive approach to classification, there arose a somewhat different orientation of psychiatric thought as a result of the expansion of psychiatry to include the noninsane, the ambulatory sufferers from mental disorder. A legal and social distinction that was convenient but certainly not scientific was made between the "insanities" and the milder disorders, called, respectively, "psychoses" and "neuroses." This distinction became even more common when the work on hypnotism of Charcot and Bernheim established the importance of ideas in the development of mental symptoms, and there began the search for the "mental causes" of the neuroses. The term "psychoneurosis" was first used in this period, though a study of the literature fails to reveal its exact origin.

These first attempts to apply scientific method to psychological data and work out some purely psychological theory for understanding and treating mental disorders took place during the same years that Kraepelin was working out his systematic classification of mental illnesses. The movement to "explain" mental phenomena rather than merely to describe them was spearheaded with enormous vigor and originality by Freud and later by Adolf Meyer in the United States. The Freudian and Meyerian views can be characterized by a word that surely must be among the most popular in our professional vocabulary—psychodynamic. The psychobiological method of clinical approach and the psychodynamic explanation of mental phenomena have proved to be the most significant elements, practically and theoretically, in the development of American psychiatry.

Freud and Meyer insisted that heredity and constitution play an important role in the development of mental illness, but their emphasis was upon the interaction of these and other factors, upon *development* rather than specific cause as the key to understanding the occurrence and the nature of psychiatric symptoms. Freud used certain of his own concepts about the structure and functioning of the human psychological apparatus as the basis for his classification. Meyer proposed to classify on the basis of the extent of the involvement of the personality. Both considered mental illness to be an adaptive reaction and both assumed a developmental rather than a specific etiology.

Freud's theories about the structure and functioning of human mental apparatus underwent almost constant change throughout his long and productive career. Consequently, the attempts at classification of mental disorders, which were an essential part of his efforts to find a scientific explanation for these disorders, also show important changes. He at first divided mental illness into (1) actual neuroses and (2) defense neuropsychoses, and he tried to demonstrate specific causes. The actual neuroses were attributed to the physiological effects of the patient's current sexual practices, while the defense neuropsychoses were attributed in each case to a repressed, painful sexual memory from the patient's childhood.

In his later writings, after the elaboration of his psychodynamic theories, Freud used the term "neurosis" in a generic way to include all the mental disorders not of toxic-organic origin. Instead of the specific etiologies that he had at first believed could

be shown, he now found it necessary to assume that the "cause" of the disorder lies not in any specific factor in the experience of the individual but in the sum of the multiple factors in his psychodynamic development. He divided the neuroses into transference neuroses and narcissistic neuroses, depending upon whether or not the patient is able to establish a relationship—or transference, to Freud's concept—with the physician, in which the patient's psychological patterns can be analyzed and interpreted and his present psychological condition affected favorably. However, Freud frequently used the term "psychosis" for those conditions in which there was a break with reality as evidenced by delusions and/or hallucinations, even though these disorders could be classified as narcissistic neuroses.

In his last written work, Freud comments(3),

> The neuroses and psychoses are states in which disturbances in the functioning of the [psychical] apparatus come to expression. We have chosen the neuroses as the subject of our study because they alone seem to be accessible to the psychological methods of our approach. . . . . [One of our principal findings is that] neuroses (unlike infectious diseases, for instance) have no specific determinants. It would be idle to seek in them for a pathogenic factor. . . . . It is *quantitative disharmonies* that must be held responsible for the inadequacies and sufferings of neurotics. The determining causes of all the varying forms of human mental life are to be looked for in the interplay between inherited dispositions and accidental experiences.

In the first decade of the present century, Adolf Meyer introduced a psychodynamic system, an approach to "explaining" the development of personality and of mental disorders, which he called "psychobiology." Meyer believed that psychiatry is based upon "all the sciences entering into the understanding of the human life-processes and life problems"(4). Meyer's classification is based upon the concept that psychiatric disorders represent adaptive reactions of the psychobiological organism and that every such reaction is an understandable result of the psychobiological development of the individual up to the occurrence of the disorder. Meyer distinguished the types of reaction on a descriptive basis and proposed a method of investigation that would give an understanding of the development of the reaction as the sum total of the interaction of multiple forces—constitutional, psychological, physiological, social, etc.

Meyer's principal divisions were "major reactions," and "minor reactions," the distinction being made on the basis of a "whole" or a "part" involvement of the personality. The "minor reactions" included mental deficiency (also called static minor reactions) and the psychoneuroses and psychosomatic disorders (also called plastic minor reactions). The "major reactions" included the classical psychoses and also epilepsy. The terms "psychosis" and "psychoneurosis" or "neurosis" were used to denote severe mental disorders as opposed to mental or emotional disturbances without gross mental derangement.

The influence of Freud and Meyer and the psychodynamic approach in general is evident in contemporary usage of the terms "psychosis" and "neurosis." Although current concepts of mental illness do not offer any clear, generally accepted basis for distinguishing between the two, and although there is as much variation in usage as there is variation in theoretical points of view and clinical technique, most present-day attempts to define psychosis and neurosis assume that they represent either quantitative or qualitative maladjustment at some stage in a psychobiological or psychological developmental process. The psychoanalytical concept is that psychosis and neurosis are different stages of the same mental process. Franz Alexander(5) describes this process as:

> . . . . the outbreak of the unconscious, repressed, primitive part of the personality. In a psychosis the process goes much further, for the difference between conscious and unconscious disappears to a large degree and the unconscious dominates the whole personality, whereas in a neurosis the principal achievement of the later ego-development, the acceptance of reality, remains more or less intact, and the unconscious tendencies penetrate the ego only in isolated symptoms, which are like foreign bodies embedded in normal tissue.

Strecker's point of view might be considered as representing that of psychobiology, when he states(6):

> . . . . psychoneuroses are essentially different from the psychoses. In general, the psychoses involve marked disruptions of personality and total abandonment of reality. In the psychoneurotic, there is much less personality upheaval and disorganiza-

tion and the hold on the environmental realities is tenacious. . . . . Psychoneuroses to be sure are maladaptations but the failure to adapt is partial, and is much nearer to a hypothetical normal than it is to the psychoses.

Even though attempts are made to interpret the diagnostic terms "psychosis" and "neurosis" according to various theoretical concepts of mental illness, there has never been established a precise and universally accepted definition of the terms. It remains, as it began, an administrative distinction based upon rough descriptive differences in symptomatology. The sole justification for using the terms has been the practical necessity for diagnostic categories as teaching aids and in administrative recording. But it has become increasingly evident in recent years that the traditional classification of mental illnesses as psychoses and neuroses is no longer useful, even administratively, because of the wide variation and growing confusion in the definition and use of the terms. An even greater objection to the distinction between psychoses and neuroses can be made on scientific grounds. Certainly the continued use of a psychiatric nomenclature that has no scientific basis in fact is a serious obstacle to the advancement of our understanding of mental illness. Mental illness remains, of course, a serious legal and social problem, but it is first of all a psychiatric—that is, a medical—problem.

One of the first to emphasize that the terms "psychosis" and "neurosis" refer to an administrative rather than a scientific distinction was Janet. At the Bloomingdale Hospital Centenary in 1921, Janet delivered an address entitled "The Relation of the Neuroses to the Psychoses," in which he called attention to the fact that any scientific difference between psychosis and neurosis was purely theoretical. The actual nature of the distinction was legal and social and in practice was made arbitrarily, on the basis of symptomatology and often on the basis of the patient's economic and social position (7).

There have been in recent years some vigorous attempts to clarify psychiatric thinking with respect to diagnostic terms, especially "psychosis" and "neurosis." Stanley Cobb has been outspoken in his objections to the vague and unscientific way in which this distinction is made. While he admits the convenience under some circumstances of making such an administrative differentiation, he takes a firm stand against the unjustifiable generalizations implied in the use of "psychosis" and "neurosis" in psychiatric nomenclature.

Psychiatry is today, perhaps more than ever before, in need of every possible aid in its efforts to broaden its scientific base and clarify its aims and techniques. Under present conditions, one of the greatest hindrances to scientific progress in this field is the confusion surrounding the use of diagnostic terms that are traditionally fundamental in psychiatric classification. Yet the terms "psychosis," "psychoneurosis," and "neurosis," which have no clear and widely accepted meaning and are the source of a major portion of theoretical and clinical difficulties, are perpetuated in official psychiatric nomenclature. It is important that serious consideration be given at this time, when psychiatric nomenclature is undergoing radical revision, to the possibility of discarding completely the problem-terms "psychosis," "psychoneurosis," and "neurosis" in favor of diagnostic distinctions that will provide a flexible framework within which psychiatric knowledge can be expanded without distortion and with a maximum of precision and clarity.

The new Nomenclature of Diseases, as proposed by the Committee on Nomenclature and Statistics, indicates some interesting new developments in statistical nomenclature. To begin with, the psychiatric disorders are placed under two main headings.

(1) *Disorders Caused by or Associated with Impairment of Brain Tissue Function.*

(2) *Disorders of Psychogenic Origin or Without Clearly Defined Physical Cause or Structural Change in the Brain.*

A new and interesting addition is that under the specific diagnosis may be added, wherever necessary and indicated, one of the following three phrases: ".X1 With psychotic reaction," ".X2 With neurotic reaction," and ".X3 With behavioral reaction."

Under the second of the main headings, *Disorders of Psychogenic Origin or Without*

Clearly Defined Physical Cause or Structural Change in the Brain, occurs the following subheading: "Psychotic Disorders." Under this subheading are included "Involutional psychotic reaction," "Affective reactions," "Schizophrenic reactions," and "Paranoid reactions," as well as, "Psychotic reaction without clearly defined structural change, other than above." The second subheading is "Psychophysiologic Autonomic and Visceral Disorders." The third subheading is "Psychoneurotic Disorders." And the fourth subheading is "Personality Disorders."

The new nomenclature does away with the old confused thinking of placing the psychoneuroses as a subgroup under the heading of "Psychoses." This implies a rejection of the concept that some hold of speaking of major and minor psychoses and thinking of the psychoneuroses as minor psychoses. From this point of view, the psychoneuroses would quite properly fall under the general heading of "Psychoses."

The new nomenclature adds a group to the classification by taking the "psychosomatic disorders" or "somatization reactions," which were formerly included under the psychoneuroses, and placing them in an independent category called the *Psychophysiologic Autonomic and Visceral Disorders*. These are "given a separate grouping between psychotic and psychoneurotic reactions, to allow a more accurate accumulation of data concerning their etiology, course and relation to other mental disorders."

One may, according to this new classification, speak of a psychophysiologic autonomic and visceral disorder with psychotic reaction, with neurotic reaction, or with behavioral reaction. It seems questionable, however, whether retaining the terms of the subheadings "Psychotic disorders" and "Psychoneurotic disorders," and then adding this new group, will clarify in any way our thinking regarding the terms "psychosis" and "psychoneurosis."

It is interesting to note that the new nomenclature has gone so far as to abolish the term "hysteria" under psychoneurosis, and the term "psychopathic personality" under personality disorders. We do find a retention of the term "neurotic traits" as one of the subheadings under "Adjustment reaction of childhood," which in turn comes under the heading "Transient Situational Personality Disturbance." The principal headings, with the exception of "Mental Deficiency," omit the word "mental" altogether and speak of "disorders."

The definitions of terms in the new nomenclature are largely descriptive, as has been the case in the past, and necessarily so, since psychiatric diagnoses are still primarily of a clinical nature rather than based upon specific knowledge of etiology. In addition to the classical descriptive material, however, the revised nomenclature includes in its definitions a certain amount of psychodynamic theory as to the nature and origin of the clinical conditions described. This combination is indicative of a fundamental problem involved in the development of psychiatric nomenclature, that is, to maintain a balance between a strict adherence to all available scientifically established facts and a provision for the scientific "explanation" of these facts by generally acceptable theories.

Bernard Hart, the distinguished British psychiatrist, in a discussion of "explanation" as the goal of scientific method, states(8):

> The "laws" which [science] formulates are not phenomena which can be observed in nature, but are constructed by the human mind in order to account for these phenomena. Science does not entitle us to construct conceptions built entirely in the air, but only such as conform to the rigid procedure of its method. That is to say, they must explain the observed facts, they must not be contradicted by other facts, and they must be capable of verification by repeated reference to experience and experiment.

If we are in earnest in our concern to develop psychiatry as a science, we must certainly reject the kind of unscientific and semantically confused nomenclature represented by the terms "psychosis" and "neurosis." The committee that recommended the changes in the Standard Nomenclature has struck out boldly in abolishing such a term as "psychopathic personality." It should be recognized that there is an even more urgent need for dropping the terms "psychosis" and "neurosis."

We suggest that the term "mental disorders" should be substituted for the term "disorders" in the two principal headings of the nomenclature. This would describe all

these conditions and would replace the subheadings now used. The main headings of the nomenclature would then read:

(1) *Mental Disorders Caused by or Associated with Impairment of Brain Tissue Function.*

(2) *Mental Disorders of Psychogenic Origin or Without Clearly Defined Physical Cause or Structural Change in the Brain.*

The terms "psychosis" and "psychoneurosis" would be dropped as subheadings under the heading *Mental Disorders of Psychogenic Origin or without Clearly Defined Physical Cause or Structural Change in the Brain.* If the difference in degree that is now the rough basis for distinguishing psychosis and neurosis is maintained as the criterion for establishing separate diagnoses, the terms, "mild, moderate, or severe" could well be substituted for the terms "with psychotic, neurotic, or behavioral reactions."

The problems we face in our efforts to develop a psychiatric nomenclature that will be scientifically valid and practically useful are extremely difficult ones, involving complexities of fact and of language far greater than we often recognize. While psychodynamic theories represent the major trend in contemporary psychiatric thinking, the measure of their success must be the extent to which they achieve the explanation of mental illnesses and the power to predict and control them. Attempts to establish this explanation and control by applying scientific method to mental disorders have met with unique obstacles because of the subjective, nonpublic nature of much of psychiatric data. Our present fund of demonstrable knowledge and well-grounded, generally accepted theory about mental illness is very meager, indeed, and the limitations of our scientific understanding in the field of psychiatry are nowhere more evident than in our use of diagnostic labels that are vague and ambiguous in meaning and have little reference to the actual clinical conditions that they purport to describe.

One of the most necessary projects in psychiatry today is to bring our system of nomenclature into line with the actual status of our scientific understanding of mental illness. Definitions of diagnostic terms must be constantly refined and clarified, especially with respect to how much psychodynamic theory is to be included as an essential part of each definition. Official nomenclature must reflect the present clinical nature of most psychiatric diagnoses as well as provide a serviceable tool for the gathering of data for research and administrative purposes. In the interest of scientific progress in the field of psychiatry, we must maintain as open-minded an attitude as possible about basic concepts and presuppositions, develop whatever methods of investigation seem fruitful, and frame a nomenclature as flexible and tentative as is consistent with present knowledge and the purposes of classification.

BIBLIOGRAPHY

1. Cullen, W. First Lines of the Practice of Physic, Edinburgh, 1776-84. Translated into French by Pinel in 1785.

2. Feuchtersleben. Lehrbuch der ärztlichen Seelenkunde, 1845. Translated into English for the Sydenham Society, 1847.

3. Freud, S. An Outline of Psychoanalysis. New York, Norton, 1949.

4. Meyer, A. Quoted in Noyes, Modern Clinical Psychiatry. Philadelphia, Saunders, 1949.

5. Alexander, F. Fundamentals of Psychoanalysis. New York, Norton, 1949.

6. Strecker, E. Fundamentals of Psychiatry. Philadelphia, Lippincott, 1947.

7. Janet, P. The Relation of the Neuroses to the Psychoses. In "A Psychiatric Milestone," Bloomingdale Hospital Centenary. New York, Society of the New York Hospital, 1921.

8. Hart, B. Psychopathology. Second edition, reprinted. Cambridge, University Press, 1950.

THE ROLE OF THE PSYCHIATRIC NURSE IN THE NEWER THERAPIES[1]

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Opinions vary as to what are the functions of a psychiatric nurse and her role in the total psychiatric treatment program. Since therapy has radically improved in the last few years, especially in the affective disorders, it is important for the psychiatric nurse to contribute her full share to management of patients.

Two problems are the scarcity of qualified psychiatric nurses and the partial use of their abilities.

Do psychiatrists really accept the psychiatric nurse and interest themselves in her needs? It is doubtful whether the average psychiatrist has tried to understand the principles of psychiatric nursing or has studied ways in which he can better delegate responsibilities to the nurse in order to improve the total treatment program. Psychiatrists should understand just what benefits psychiatric nurses can contribute to a more adequate management of their patients.

Not only is there a dearth of really qualified psychiatric nurses, but very little real psychiatric nursing is carried out in otherwise good psychiatric hospitals and units. Even the special psychiatric nursing committee of the Group for the Advancement of Psychiatry admitted after several conferences that members must first educate themselves as to the specific duties and responsibilities of a well-trained psychiatric nurse.

Chief Nurse—Functions and Duties

The chief psychiatric nurse, in our opinion, should have policy-making authority independent of the psychiatric staff members, hospital administrators, and general nursing staff. She should of course cooperate with these groups through frequent conferences. If she is thoroughly competent her judgment should decide psychiatric nursing policies. Full competence implies a mature, tolerant, self-assured woman, whose background includes wide general knowledge and college training. In addition to her technical competency she must be free of emotional conflicts.

The chief nurse should develop, with advice from the psychiatric staff, all rules and regulations of her department. Varied experience of the senior author (A. E. B.) has proved that regulations should focus around nursing needs, in order to avoid misunderstanding and friction between nurses and aides and to maintain proper esprit de corps. The final criterion is of course what procedures most benefit the patients.

Fitzsimmons(1) expresses clearly how the nurse appreciates being permitted, within her abilities, to use her own judgment and initiative. This freedom challenges and stimulates her to develop her work and that of her staff to the utmost.

The chief nurse's major responsibility is the training of an auxiliary staff of assistants to conform to her standards, an important duty because of the lack of psychiatric nurses. Complete abolition of all restraint methods except seclusion quarters is essential in the modern psychiatric nursing regime. Other intramural nursing relationships and requirements depend upon the scope of therapy within the hospital's specialized fields such as social service, clinical psychology, psychotherapy, and occupational and recreational therapy. Close work with the psychiatrist is necessary in such special therapies as shock therapies, fever therapy, lobotomies, narcoanalyses, antabuse in alcoholism, and other drug treatments. Good psychiatric nursing also has an excellent field in the successful management of such psychosomatic problems as anxiety, hypochondriasis, and introspectiveness in other functional complaints.

There has been wide discussion of *Nursing of the Future*(2), a study headed by Esther Brown. A new type of professional nurse is

[1] From the Department of Psychiatry, Herrick Memorial Hospital, and The A. E. Bennett Neuropsychiatric Research Foundation, Berkeley, Calif.

recommended, the training to be aided by federal funds. The study showed 83 hospital training schools as unqualified. All hospital training schools would be abolished or turned into training of practical nurses, who would have charge of most bedside nursing. Professional nurses would be nationally accredited after university training, and would teach or supervise.

In our opinion this radical change requires educational training beyond the needs for intimate, personal nurse-patient relationships. Most psychiatric nurses still want to care in part for their patients, and in this close care gain great satisfaction. Psychiatric nursing can never become an aloof, sterile relationship. Close daily contacts strengthen rapport between patient and nurse and actually bring about many recoveries, as Biddle notes(3). Practical nurses can also attain this relationship, but the experienced psychiatric nurse is much better able to use it objectively. A good theoretic background plus practical training and experience in mental wards provides a satisfactory course for psychiatric nursing.

The Psychiatric Nurse and Community Activities

Just as the psychiatrist must actively interest himself in various mental hygiene community activities, so should the psychiatric nurse also participate. Her responsibility is to join mental hygiene societies, consult with welfare agencies and work in outpatient clinics, and thereby to practice preventive psychiatry and help educate the public. Her interest in these fields aids greatly in overcoming public antagonism toward psychiatry and in allaying fears, prejudices, and superstitions. Community health programs will increasingly demand the inclusion of psychiatric nurses, as pilot programs in outpatient clinics demonstrate the nurse's worth. The public health psychiatric nurse has already attained considerable community importance by demonstrating her value.

The Role of the Nurse in Specialized Therapies

Insulin Treatment.—In subcoma treatment of patients for anxiety and weight gains the nurse needs the same full instructions as do residents in the complete care, including details of physical management of the patient and accurate charting of all possible complications. Successful management of this therapy is entirely a nursing responsibility. Two recent papers(4, 5) list the nurse's important contributions to all types of insulin treatment.

Nurses should be picked for their efficiency and interest in this procedure. The nurse's friendly, cooperative attitude at the termination of coma is of great therapeutic value. She must be alert to note the patient's difficulties and problems, often mentioned at this time, and to chart them for psychiatric interviews. Often the nurse can pick up clues as to conflictual material. She must treat understandingly the overbearing, demanding, aggressive patient, who learns that antagonism is unnecessary to gain attention. The nurse's friendly attitude encourages and maintains euphoric reactions. Her close, prolonged contact with the patient during treatment aids therapy and directly accounts for much of the success or failure of treatment, in our opinion.

Electroshock Therapy.—Successful management is definitely linked with good psychiatric nursing. Sherman and Charbonneau (6) have itemized good nursing techniques in this therapy. The nurse needs careful instructions in administration of such adjuvant drugs as curare and barbiturates prior to the shock treatment, prevention of accidents, and all phases, reactions, indications, and contraindications of therapy. Her role is especially important in gaining the patient's cooperation and allaying his anxiety. Her advice in daily staff conferences helps greatly to decide the frequency and spacing of treatments, since patients tell the nurse first about their reactions to treatment, and she has the best chance to estimate degrees of mental confusion. Her explanation and reassurance decrease the patient's fear of treatment as the course progresses.

Careful nursing management protects the patient from psychologic trauma and avoids his witnessing other patients in or shortly after treatment. Nurses keep patients busy with activities and evade discussion of details of treatment. They also help with management of relatives, to whom they explain

aspects of therapy and give reassurance. Nurses' simple explanations, reassurances, and encouragement of patients toward varied activities constitute valuable psychotherapy and aid greatly in the sustained results of electrotherapy. During the convalescent stage the nurse takes the patient on outside trips and discusses certain problems that may confront him upon return home. Results of these interviews are reported back to the psychiatrist.

Lobotomy.—The well-trained nurse needs basic information on indications, various techniques, psychologic effects, and possible complications of prefrontal lobotomy procedures. Actual experience with lobotomized patients prepares the nurse to understand the changes in emotional reactions and behavior, and to develop skills in aiding the patient's rehabilitation and social recovery. Above all, she helps bridge the gap between the patient's hospitalization and readjustment to family life.

Friedmann's excellent article(7) specifies the need for close postoperative observation; the best ways whereby to retrain toilet and eating habits and personal hygiene; methods to counter the patient's distractibility and inertia; and simple routines and other means to get the patient to help himself as soon as possible, whereupon psychotherapy can begin. Two other articles(8, 9) describe the procedure or emphasize the nurse's rehabilitative role.

Jones and Shanklin(10) remark that in transorbital lobotomy the immediate convalescence differs little from that following multiple electroshock. We would agree. The nurse should observe the patient carefully for the first 8 postoperative hours, noting physical signs if he is not up and talking within an hour. The patient should remain in hospital 3 to 4 weeks if possible. During this time the nurse helps greatly both patient and family in their adjustments to the therapy.

Psychotherapy.—Since professional nurses have taken responsibilities formerly delegated only to physicians, the nurse needs more basic instruction in therapy. This trend will increase in psychiatry. Psychiatry must have greater emphasis in the basic curriculum, and psychiatric nursing affiliation must be required for all graduate nurses.

Despite the fact that most psychiatrists seem to ignore the role of the psychiatric nurse in psychotherapy, all nurses in psychiatric wards do psychotherapy of one kind or another by their contacts with patients. This should be used purposefully. Because of various pressures, psychiatrists can spend less and less time upon wards and therefore must delegate more responsibility to nurses. Often they delegate responsibility by absence rather than by careful instruction and training. Nurses must in such cases give psychiatric reassurance and suggestions in order to satisfy the patient while awaiting the physicians' irregular visits. How much better to face these facts intelligently and under supervision to instruct the nurse in developing these techniques.

Postgraduate training must emphasize more the role of psychotherapy. The nurse must thoroughly understand psychopathology and the various theories and techniques of psychotherapy. Specialized and supervised training as to her part in psychotherapy can then proceed.

Instruction on the highly important nurse-patient relationship should include ways in which to allow the patient to act out his feelings about the nurse, who almost always represents a family figure to the patient. For example, the patient may act aggressively toward the nurse and may be extremely demanding, dependent, hostile, erratic. Psychotherapeutically her management of this behavior can be very effective because she has learned why the patient is anxious, suspicious, or hostile. She needs to know his complete record, personality background, and basis of his illness, and to feel free to discuss them with the attending psychiatrist. With this knowledge, mutual discussion, and her familiarity with the patients' behavior she can assume under supervision such responsibilities as explanation, reassurance, persuasion, encouragement, and suggestion. Whenever the direction of therapy becomes complicated or otherwise difficult she will always suggest that the patient discuss the problem with his doctor.

As psychotherapy proceeds, conferences should keep the nurse informed as to the

patient's progress, so that she can adapt her attitude accordingly. As noted, the nurse particularly aids the late convalescence in electroshock by helping to orient the patient to his return home.

Certain nurses can be trained to take excellent psychiatric histories and to obtain other detailed information, in our experience. The history-taking helps to establish rapport and makes the nurse from the start an aid in psychotherapy, thereby saving much of the physician's time and shortening the treatment program. The nurse should also participate more in group psychotherapy, as she is trained to do on many British mental wards. From her familiarity with the patient on the ward she becomes a key figure and facilitates establishment of rapport.

In these ways the psychiatric nurse of the future can contribute a great deal in both individual and group therapy if the psychiatrist will take the time to encourage and guide her. This participation will increase her emotional satisfactions in a healthy nurse-patient relationship. Just as we now utilize social workers and psychologists in teamwork psychotherapy, so should we use more effectively the psychiatric nurse. Indeed, as Russell(11) points out, the well-trained and efficient nurse is in far better position than are these workers to aid in psychotherapy. Haun(12) also discusses the general circumstances and extent to which the psychiatrist can delegate his responsibilities to ancillary workers "who in his considered opinion can benefit the patient."

Finally, I see another important role of the psychiatric nurse in the future—to become actively interested in research, especially that related to improving psychiatric nursing methods. Theilbar(13) has outlined procedures for the nurse to investigate such problems as control of the patient's environment, the effect upon him of personnel and of other patients, nondirective counseling, therapeutic grouping of patients, and new techniques whereby to stimulate rapport.

As the psychiatric nurse assumes these greater professional responsibilities she must necessarily be released from much detail of bedside nursing. The practical nurse, aide, and other auxiliaries will take on more of these duties.

An interested, cooperative attitude on the part of the psychiatrist will go far to attain these practical objectives in psychiatric nursing.

BIBLIOGRAPHY

1. Fitzsimmons, Laura. What the nurse looks for in the administrator. Am. J. Psychiat., **107**: 176, 1950.

2. Brown, E. L. Nursing for the Future. New York: Russell Sage Foundation, 1948.

3. Biddle, W. E. Nurse and "spontaneous" recovery in schizophrenia. Am. J. Nurs., **49**: 371, 1949.

4. Clawson, G., and Peasley, E. Nursing care in insulin therapy. Am. J. Nurs., **49**: 621, 1949.

5. Gayle, R., and Neale, C. Subshock insulin therapy. Dis. Nerv. Syst., **10**: 231, 1949.

6. Sherman, C., and Charbonneau, L. Electric shock therapy. Am. J. Nurs., **48**: 294, 1948.

7. Friedman, Evelyn. Nursing aspects of the treatment of lobotomized patients. Bull. Menninger Clin., **14**: 138, 1950.

8. Sands, I. Frontal lobotomy. Pub. Health Nurs., **41**: 102, 1949.

9. Behnken, P., and Merrill, E. Nursing care following prefrontal lobotomy. Am. J. Nurs., **49**: 431, 1949.

10. Jones, C. H., and Shanklin, J. G. Transorbital lobotomy in institutional practice. Am. J. Psychiat., **107**: 120, 1950.

11. Russell, W. Rôle of medical administration in psychiatric hospital treatment. Am. J. Psychiat., **105**: 721, 1949.

12. Haun, Paul. Psychiatry and the ancillary services. Am. J. Psychiat., **107**: 102, 1950.

13. Theilbar, F. Research in psychiatric nursing. Ment. Hyg., **33**: 115, 1949.

A SURVEY OF CONDITIONS OF PRIVATE PSYCHIATRIC PRACTICE THROUGHOUT THE UNITED STATES AND CANADA [1]

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In an attempt to gain some information relevant to the private practice of psychiatry in the United States and Canada, by a sampling procedure, a questionnaire was distributed to all members and fellows of The American Psychiatric Association with the request that those in the private practice of psychiatry fill in the required data and return the forms for summarization. Of the 5,680 members and fellows (according to the latest APA directory and information from the Office of the Medical Director) having residence in the United States proper and Canada, 1,850 are partially or wholly devoting their time to the private practice of psychiatry. Of these in private practice, 627 or 33.8% responded. Completed questionnaires were received from psychiatrists in all the states but 9, namely: Nevada, Idaho, Wyoming, New Mexico, North Dakota, South Dakota, Mississippi, South Carolina, and New Hampshire. Seventy-five percent of the completed questionnaires were received from the states east of the Mississippi River and 25% from states west of this arbitrary line. When plotted geographically, the replies from the various areas of the United States were in reasonable ratio to the density of population and to the number of physicians practicing psychiatry in those areas.

On the basis of the data thus assembled, at least a crude preliminary picture of some aspects of the private practice of psychiatry can be constructed. In doing so, no attempt will be made to evaluate some of the information tabulated because it was obvious that there were defects in the presentation of some of the questions, and it was evident that some other questions evoked personal resentments, irritations, and even led to the concept on the part of a few that there is being waged "a war between psychoanalysis and psychobiology" and that the questionnaire was but a means of supplying ammunition of one sort or another for "one of the sides." Suffice it to say, all the remarks of such a character seemed only to reflect some personal unrest, insecurity, irritation at being presented with another form to fill in or general dissatisfaction—such as would be expected in any large professional group working under excessive pressure.

The crude composite picture, in general, has arbitrarily been constructed in terms of the physicians and their immediate personal problems connected with practice, patient loads, and a few of the socio-economic aspects of private-practice psychiatry.

The average age of the practitioner of psychiatric medicine today is 41 years (70% between 30 and 50 years of age). Each had spent on an average 5 years in hospital residency. Sixty-two percent of the physicians responding have been in private practice less than 10 years and two-thirds of these have practiced less than 5 years. Two out of every three are presently diplomates of the American Board of Psychiatry and Neurology. Forty-three percent are practicing in a city of a million or more population. Nearly an equal number (41%) are located in cities having populations of 250,000 or less.

Interestingly, the distribution of psychiatrists in private practice and who participated in the survey is approximately the same in cities ranging from a population of three-fourths million to those with less than 50,000.

Approximately 51% of those replying considered available psychiatric facilities adequate. This figure, however, might be misleading in terms of the country as a whole. A little over one-half of those reporting from New York State alone declared that the situation in that state was overcrowded. Certainly west of the Mississippi, and through the southern area from coast to coast, there is an indicated need for both additional psychiatrists and psychiatric facilities. Only 11% of all the participating physicians indicated that there is *no* existing need for

[1] Read in the Section on Private Practice of Psychiatry at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

more neuropsychiatric hospital beds in their communities.

The majority of responding psychiatrists indicated that they are practicing general psychiatry and/or so-called "neuropsychiatry" and about one-third emphasize psychoanalysis. Less than one-sixth indicated that they did any child psychiatry.

Less than one-sixth of the doctors replying did not give lectures to the laity during 1950. The majority contributed anywhere from one to over 50 hours for this purpose during the year and two-thirds of all devoted 6 to 30 hours to public education during the past year.

Likewise, the majority (80%) participated in teaching programs for medical students, postgraduate students, nurses and social workers. One-fourth hold reserve commissions in the armed services, one-third published one or more scientific articles during the preceding year, and nearly one-half spent some time in research.

From the point of view of leisure time, all psychiatrists found it necessary and possible to afford themselves some vacation, the vast majority taking 2 to 6 weeks' vacation per year—the average being one month. One-third of the physicians take their holiday at one time and approximately one-half do so at separate times.

According to the survey, the psychiatrist in the United States averages 36 hours per week in his office. His time is divided about as follows: up to a maximum of 75% in the office, up to 30% in hospitals, and up to 6% in making house calls. He sees on an average 25 to 30 patients a week, of whom 3 to 5 are new patients. Patients undergoing office therapy are usually seen once to 3 times weekly, 60% being seen either twice or 3 times weekly. A few physicians reported seeing patients 4 to as many as 20 times weekly in the office.

In addition to office patients, the American psychiatrist maintains a hospital load of approximately 5 patients, although a few carry an average of 6 to 20 in hospital. The average hospital patient is seen about once daily (average 5 to 7 times a week). According to the survey, two-thirds of the psychiatrist's hospital affiliations are maintained for both the teaching and therapeutic privileges afforded him.

Thirty-six percent of the reporting doctors use electroshock in their hospital practice and only 17% in their offices, the average number of treatments given per patient per week in each instance being 3. Nearly all replies indicated a need for some type of "short-term" psychotherapy, a possible expression of the pressure under which the average psychiatrist works (94% of all available time filled). Practically all (81%) subscribe to the use of medicinals in symptomatic and supportive therapy. Twenty-four percent of the reporting psychiatrists utilize psychoanalytic procedure exclusively.

From the economic point of view, 83% of our reporters' income in 1950 was at least equal to, and generally higher than, that in 1949. Of the total receipts, the average psychiatrist must spend 29% to cover operating and overhead costs. He loses, on an average, only 2% of his potential income in the form of uncollectible bills—possibly an indication of general patient satisfaction with the services rendered. In addition to the time spent each year in contributing to public and professional education, the reporting doctors give, *without charge*, from 5% to 40% of their clinical time to the care of patients. The average American psychiatrist, according to this survey, devotes 20% or one-fifth of his professional life to his patients at no cost to the patients.

This survey indicates that, to the patient, the average cost per psychiatric examination hour is between $15.00 and $25.00 and that the average charge for psychotherapy is between $10.00 and $15.00 per "hour." In general, there appeared to be very little difference in average charges for such services in the various areas of the country.

Information pertaining to the American psychiatrists' sentiments toward health insurance was not reliable, probably because of the questionnaire inadequacies. About three-fourths of those responding expressed the opinion that some type of voluntary, prepaid health insurance might be worthy of consideration. An equal number were certainly opposed to compulsory federal medical insurance.

Finally, the one of few points on which all were agreed was that private-practice problems should be stressed more in postgraduate psychiatric training.

CULTURE, SOCIETY AND PERSONALITY: A RESTATEMENT [1]

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The study of the relationship between culture and personality has been one of the major interests of social anthropologists, sociologists, and social psychologists for two decades. Significant contributions have been made by all three sciences. Nevertheless it is still in a confused and controversial state. This arises from the divergent formulations of the problem, each formulation springing from the implicit and explicit postulates of the particular scientist, which again arises from the historical development of his own science. Of recent years, however, there has developed the possibility of an approach that may become acceptable to a large number of social scientists of all the disciplines concerned. It is intended in this brief paper to make a restatement of this particular approach in the hope that discussion may further clarify it.

An oversimplified statement of what might now be called the traditional approach is that there are individuals, that these individuals live in society and, growing up in his society, each individual's process of development is influenced by the culture of the society of which he is a member. The resultant product, in the individual's behaviour, we label personality. Thus, it is said, the development of each personality results from all his experiences, including his interaction with other individuals. Thus, further, there is a cultural component in each personality, but also there are individual components. In this scheme, the role of the sociologist and of the social anthropologist is to study this social component of personality, leaving it to the psychologist to study the totality of personality and the individual differences. Culture and society thus interact with personality, and one of the meeting grounds of the various disciplines is in the area of this interaction.

In contradistinction, another basic concept is emerging. This has never been absent, but is now being stated much more explicitly. Simply (and therefore inadequately) stated this concept involves acceptance of the point of view that when we talk about culture, society, and personality we are talking about different aspects of the same phenomenon. The individual is not something potentially outside society, but is part of it. Society is not an abstraction that can ignore individuals. It is a collectivity composed of individuals interacting in an ordered manner.

At this point we find ourselves with three terms: culture, society, and personality. I propose to throw one of them overboard in the interests of clarity; the term I have selected for sacrifice is the term *culture*. In this context, at least, I suggest that it obscures rather than clarifies the issue. It is an abstraction that denotes all customary modes of behaviour characteristic of any group and is so comprehensive as to be useless. It lends itself to such statements as: "Culture impinges upon the personality;" "Culture influences the personality;" "Culture interacts with the individual to produce the personality."

All these formulations are so vague as either to be misleading or to produce a vagueness of thought that obscures all issues. A vague thing like culture does not and cannot impinge upon the individual. What happens is that individuals develop in interpersonal relationships, these in turn showing an ordered form characteristic of the society of which they are a manifestation. I do not necessarily expect the concurrence of fellow anthropologists in thus slighting one of our most sacred terms but have personally found it expedient to think without it. We are thus left with two terms: society and personality.

Society may be conceived as a complex grouping of individuals, not merely collected together but as units interacting in an ordered, though not necessarily in a perfectly

[1] A revision of a paper read at a meeting of members and graduate students of the departments of anthropology, psychology, sociology, psychiatry, philosophy, and social work, University of Toronto, February 6, 1951. I am much indebted to my colleague, Dr. E. S. Carpenter, of the department of anthropology, for suggestions and critical comments.

integrated, manner. The scientist whose interest is in the uniformities visible within any social group describes the rules of such interaction as the "social structure." He thus makes a limited but expedient abstraction, but the abstraction continues to be expedient only insofar as it is borne in mind that it is an abstraction.

From the point of view of the psychologist interested in individual development, the individual is abstracted, the abstraction again being expedient only insofar as it is treated as such.

The basic phenomena are not the behaviour patterns of man, considered as an individual affected by society, nor are they the social structures that influence man. They are the behaviour patterns of *man-in-society*, the only way in which one can consider man as human. Personality, in this context, is a study of man, at any stage in his individual development, as a unit interacting with other units, and personality, so considered, is an expedient abstraction.

Stated in another way, *man-in-society* may be considered as a continuum. The continuum is made up of personalities in interpersonal relationships. In the time process, each personality changes; in the time process, the society changes; we are saying the same thing. If we transect the personality at any given point in the continuum we are in a position to describe it as it is in that stage of its history. (Of course, we have not the scientific tools to do this completely; our descriptions are, of necessity, partial and limited.) If we consider the continuum longitudinally, in the case of the individual, we are studying the process of development and change in personality. If we consider the totality longitudinally, we are studying social process and social change.

One of the interests of the psychologist is the study of individual differences. He may agree with what has gone before, but say it is incomplete. It apparently takes no account of the unique combination of experience that goes into the development of each personality and that, by oversimplification, it falsifies. It may be useful to summarize certain aspects of the life history of an individual in the *man-in-society* context.

When the individual is born, he may be said to be without personality. Personality develops as the individual enters into interpersonal relationships with other individuals. The first interpersonal relationships are within the family. And here, I point out another type of problem with which I do not propose to deal: What relative weight have these earliest interpersonal relationships in the structuring of the personality? Some schools of thought ascribe to them not merely priority, but dominance. Others ascribe to them significance because of their priority but not necessarily a dominance precluding further development. This is, of course, a basic problem and it is not discussed further here merely because the argument may be developed without further reference to it.

The personality further develops as the field of interpersonal relationships expands and there emerges the adult personality, moulded by the sum total of his interpersonal relationships, by his social experiences, by the role he has played and is playing.

The analytic social scientist may at this point object. He may note, rightly, that each family is different, that the experiences of each individual in the society will thus be different and that the personalities in any social group will have only certain social components in common, the remainder being individual. This alleged common component is called by Kardiner *basic personality*, by DuBois *modal personality*, and by Fromm *social character*.

This objection may be met, it is suggested, by thinking of each family, or each system of interpersonal relationships within a given society, not as unique, but as variations of a common pattern. To use a crude morphological analogy, each human body is unique, but as a particular example of the species *homo sapiens*. We do not say of the individual body that it is partly human, partly individual; each is one of a species, each, in its size, proportions, and so on, is idiosyncratic. Similarly with personality, each is idiosyncratic, each is one of the species, a personality that belongs to a social system and has developed its own idiosyncracies as a result of the educational process within the limits possible within the society. Such a bald statement does not, of course, do justice to the infinite variations possible, but it

does give a framework within which these innumerable variations are possible. And it does away with the false (and inexpedient) dichotomy between individual and society, between personality and social system.

Within the suggested conceptual framework, a number of lines of thought might be developed. I shall remark on only a few. First, if the process of individual development is studied, when we say that "a child becomes socialized or enculturated" (to use Herskovits' term), we mean simply that the child's personality is structured in accordance with the interpersonal relationships in which he has participated. This becomes meaningful if we consider the cases of feral children. Disregarding the highly suspect accounts of children brought up by wolves or other wild animals, we have authentic records of a few children brought up in attics in Pennsylvania, where the interpersonal relationships were reduced to the minimum consistent with bare physical survival. These children responded to only a few significant symbols associated with feeding and other indispensable physical care. Entering into no complex relationships with other people they did not develop human personality traits, they remained psychologically unstructured organisms. Personality is only possible, is only conceivable as the individual aspect of structured social interaction.

Second, when we say that "cultures change," we mean, quite simply, that personalities change. Cultures do not change, *causing* a change in personality; cultures, or rather societies, only change *as* personalities change.

Third, when we say, that "cultures meet" we do not mean that cultures ever have met or ever could meet. We mean that people meet and, in the process of mutual adaptation, the personalities are modified; and the members of both societies so affected, interacting with other individuals within their respective societies, initiate changes in those other individuals.

Finally, when in the process called acculturation, values and goals cease to have meaning for an individual, portions of his personality have been rendered completely useless. A complete loss of values and goals would mean a complete disorganization of the personality.

If an agreed formulation of the problem is achieved, scientific collaboration between the various disciplines is facilitated. This does not necessarily mean that joint research projects be undertaken, though that would be one desirable development. Of greater importance would be the improvement of communication between the sciences, so that the relevance of work done by one would be more easily comprehended by the others. Scientific intercommunication is increasing and the need for it is becoming more widely realized. Acceptance of the fact of certain communities of interest would expedite the process.

None of these ideas is original. The concepts were implicit in the works of G. H. Meade and of Edward Sapir, to cite almost at random only two of many possible examples. The implicit is rapidly becoming more explicit and this paper is simply an attempt to write down a statement of a present-day trend in scientific thought.

EXPERIENCES AT THE MOSHER MEMORIAL PAVILION OF ALBANY HOSPITAL SINCE 1902 [1]

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We present an outline of the development and present functioning of one of the oldest psychiatric services and teaching units attached to a general hospital. With the progress of psychiatry, there have developed new viewpoints and approaches to the problem of emotional illness. These have resulted in different concepts about the functioning of such units. We would like to present the experiences of 50 years not only because of their historical interest but also with the purpose of contributing towards the further progress and maximum functioning of such units.

Background and Origin

In 1902 Dr. J. Montgomery Mosher initiated Pavilion F, the psychiatric section of the Albany Hospital, subsequently named after him. Before this time similar attempts, chiefly in New York City and Philadelphia, had proved unsuccessful. New York Hospital in New York City had given up its mental patients to a separate psychiatric hospital, "Bloomingdale," in 1821. The Philadelphia General Hospital moved all mental patients to its psychiatric hospital in West Philadelphia in 1841, after having kept them with medical and surgical patients since 1751. The reasons for these earlier unsatisfactory experiences were, apparently, (a) the disagreeable features of caring for chronically ill mental patients in general hospitals, and (b) the occasional "disturbances of the peace" by noisy and overactive inmates. The observation wards of Bellevue Hospital were in operation but definitive treatment was not undertaken.

From the beginning of Mosher Memorial, definitive and symptomatic care was given to the psychiatric patients, the greatest percentage of admissions being the major psychoses, both organic and functional. Three definite objectives were realized at that time, namely, (a) the screening of patients for the state hospital by early diagnosis, (b) prompt intensive treatment to avoid certification where possible and (c) better facilities for the custodial care of patients for whom relatively short, intensive treatment could not bring sufficient remission to prevent state hospitalization.

Admissions, Clinics, Community Service

In its first year of operation, Mosher Memorial admitted 174 patients and in its first 10 years, 2,799. In 1949, admissions had risen to 1,470 annually, and in the last 10 years totalled about 11,000. The diagnoses remained approximately the same, about 70% psychoses and 30% neuroses with female admissions slightly in excess of males. There has been a gradual trend, more apparent over the past 10 years, toward an increased admission of the neuroses. Albany County Department of Public Welfare contributed largely to the initial cost of the psychiatric annex with the provision that its county patients be admitted when indicated, with the result that, today, the service census averages about 20-30% county cases. Weekly outpatient psychiatric service was established soon after Mosher Memorial was started, under the supervision of its director. Consultation service for the hospital was favored, no doubt, by the more personal contacts possible between physicians of a smaller community as well as the proximity of the physical facilities. A child guidance clinic for the community was started in 1934, also under the supervision of the director of Mosher Memorial. This service was discontinued during World War II, but has recently been resumed on a full-time and larger scale. Mental hygiene clinics for veterans were started in 1948; these are now functioning twice weekly under the supervision of the director and the Veterans Administration.

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Teaching and Research

Teaching was started with the founding of Mosher Memorial when the senior students of the medical school met one-half day a week for bedside teaching and case presentations. This developed into a 4-year teaching program of psychiatry at the Albany Medical College with the service presenting both didactic lectures in the first 2 years, and clinical training in the last 2 years of the medical course. With the increased requirements for training for certification by the American Board of Psychiatry and Neurology, attention is now more sharply focused on the graduate training program for the house staff. The building of a large Veterans Hospital near Albany Hospital with approximately 200 beds for psychiatry and neurology will aid in the expansion of psychiatric training facilities in this area. Research is done under supervision of the director of Mosher Memorial and on some projects in conjunction with the directors of the basic medical science departments of the Albany Medical College. Research and teachings are now being expanded with the support of Foundation fellowships and Federal grants.

Physical and Administrative Aspects

From its beginning, this psychiatric service has been a separate physical unit, connected with the hospital by enclosed corridors. It has remained, essentially, a closed ward section, and both floors, one for male and one for female patients, contain isolation rooms. It is noteworthy, however, that over the last 10 years there has been a growth of the "open ward psychiatric section" so that today about one-third of the patients are "open ward," general hospital patients. In its first year of operation, any attending physician of Albany Hospital, either medical or surgical, was allowed to admit his own patients to the psychiatric section and to care for them personally. This, however, caused complications and was discontinued a few months later. The system established in 1902 whereby psychiatrists assumed responsibility for all psychiatric patients in Mosher, is still in existence today. At this early time, therefore, responsibility for the emotionally handicapped patient's care passed into the hands of the psychiatrist, and the internist or surgeon relinquished his supervision, but not his critical observation and attention. This system is generally in effect today and is now taken for granted. It is of interest, however, to note this early "trial and error" period. A psychiatrically trained nurse was placed in charge of the nursing care for this service, although the idea of female nurses caring for male psychiatric patients was not generally accepted at that time. Thus, while chief nurses on a psychiatric service are standardized today, this was also an innovation in the early days of Mosher Memorial.

From the beginning, Mosher Memorial has been an independent service in the hospital separate from the medical, surgical, and other services. Today it is a major service in both the hospital and the medical college. In earlier days, its junior medical personnel was drawn from internes of the medical service; today, it furnishes training for 3 assistant residents and a resident. Internes also receive 3 to 6 months of training.

Treatments

The earlier treatments in Mosher Memorial consisted chiefly of physical therapy, chemotherapy, and "moral" treatment (a forerunner of modern psychotherapy). With the advent of shock therapies in the late 1930's, considerable emphasis was placed on the physiological aspects of therapy. Ambulatory electroshock treatments were started shortly afterwards, a precursor to the "day hospital" concept. Psychological treatments, including psychotherapy and narcosynthesis, are used on the inpatient service, but are practiced more extensively in the psychiatric outpatient and mental hygiene clinics. The psychologist and the psychiatric social worker are assuming more importance in the functioning of the section. Occupational therapy and rehabilitation have been done with varying degrees of emphasis throughout the history of Mosher Memorial.

Present Activities

General activities during 1949 show admissions of 1,470, discharges to state hospitals being 15% of this figure, a marked decrease from 10 years ago owing to the

advances in treatment, such as shock and subshock therapies, narcosynthesis, and psychotherapy. The maximum capacities are 50 patients on closed wards, in addition to which 25 can be accommodated on open wards in the general hospital. Electroconvulsive treatments given were 4,000, insulin comas 1,000, subcoma insulins 1,000, narcosyntheses 750, outpatient psychiatric clinic visits 1,000. Psychiatric consultations to other services of the hospital numbered 250.

Discussion and Conclusions

This has been a brief résumé of the development and activities over a period of 50 years of the oldest psychiatric service in a general hospital in this country. It is pertinent to examine at this point the advantages of this type of service in a general hospital.

First, we believe that it fulfills its original purpose, namely, that psychiatric patients from a community are carefully screened instead of being abruptly transferred to an institution for the chronically mentally ill, such as the state mental hospitals. This is self-evident for the minor personality disorders but is particularly applicable to the psychoses. With proper care, no toxic psychoses such as the alcoholic, the barbiturate, exhaustive, and many other endogenous and exogenous psychoses, need be certified to a state hospital; and certainly, the affective psychoses are generally, today, so amenable to comparatively short-termed intensive therapy that many patients suffering from these types of disorder can be returned home in good remission. Many of the acute schizophrenic reactions can be treated and discharged to the home, in remissions of varying lengths, supportively treated on an outpatient basis, with ambulatory shock treatments, clinic and home visits. Even the organic psychoses need not be promptly certified to a state hospital. The paretic patients can now be treated with penicillin and malaria, state hospitalization being averted in many cases. Other types, such as the senile and arteriosclerotic disorders, can, in some instances, be treated symptomatically for affectivity symptoms, and sufficiently improved to be returned home for varying periods of remission.

Secondly, there are special advantages from the preventive viewpoint, not only in service to the community by the outpatient and mental hygiene clinics, which are ostensibly for this purpose, but in the close relationship of the psychiatric consultation service with the other services in the general hospital. The psychiatrist can evaluate emotional components, and possibly avert more serious mental disorder. Psychiatric consultation and evaluation are easily obtained by specialists in other branches of medicine, and by the general practitioner. The patients in need of psychiatric care are afforded the opportunity to meet the psychiatrist as a consultant, which helps to overcome their initial fears and resistance to psychiatric treatment, and to accept the fact that their illness is an emotional one. In this group are those who would never come directly to the psychiatrist's office. It is not uncommon for some person in the community to avail himself of this rather circuitous but still available route, in order to get the psychiatrist whom he really wishes, and realizes the need to consult.

Thirdly, this type of service in a general hospital affords an excellent means of teaching clinical psychiatry. The medical student is able to see psychiatry in its most general and basic aspects. He sees a cross section of all psychiatric disorders, both acute and chronic. Moreover, he has an opportunity to see psychosomatic conditions, both on his own, and the other services of the general hospital whether labeled by psychiatric terms or given medical or surgical diagnoses. He can learn mental hygiene and child guidance principles at the clinics that are supervised by and coordinated with the service. The psychiatric service in a general hospital, therefore, offers an exceptional basic general orientation for the student without undue emphasis on the numerous subspecialties and ramifications of present-day psychiatry. This applies to the medical students, the internes, and graduate students as well as to the nurses. This broad viewpoint and approach to general psychiatry has its advantages for research selection, aided by the availability of the medical school facilities as well as the other specialty services of a teaching hospital.

Mosher Memorial has now had a long, time-tried, working experience. That there are advantages is shown by the increasing number of such units being established throughout this country, which, while they may differ in various respects, both in regard to physical facilities and psychiatric approaches, still have in common the basic purpose of the psychiatric service in the general hospital.

A SURVEY OF SZONDI RESEARCH[1]

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INTRODUCTION

The Szondi test is a new instrument that has evoked much interest. As yet, few experimental articles pertaining to this technique have appeared. This is unfortunate, since so many clinicians anxiously ask, "What about the Szondi?" Many have had to rely upon their own rather unreliable "personal validations" or clinical experiences with the test because of the relative unavailability of research results. In spite of the usual ethics that pertain to the application of an unvalidated instrument, many psychologists are applying the test routinely to their patients. Others are waiting more patiently for the results of studies, which will appear eventually in the journals, before deciding whether or not the test merits adoption.

This review is designed to acquaint the reader with the general status of research with the Szondi and some of the findings to date. The majority of the Szondi research has been reported at annual psychological association meetings or is now in press. All experimental reports available to the reviewer have been included and any selection that may have operated was unavoidable. Critical summaries are appended to each section to provide a certain integration to this collection of studies. A general viewpoint or conception of the Szondi technique is obvious and readily admitted by the reviewer. It is hoped that this viewpoint will lend a certain continuity to this review.

It will be recalled that the Szondi test of personality utilizes 6 pictures of different mentally ill Europeans for each of 8 diagnostic categories. The pictures are presented 8 at a time (one from each category) and the subject selects the 2 he likes most and the 2 he dislikes most. The total profile depends upon the total number of likes and dislikes selected in each category after the presentation of all 6 sets. The selections in each of the 8 diagnostic categories are viewed as representing the state of tension in a corresponding personality variable, or *need-system*, of the subject. It is presumed that these need-systems bear an important relationship to personality and general behavior.

STIMULUS PICTURES

One of the most fundamental assumptions of Szondi is that the different pictures offer true *stimulus* differences. Physical differences between pictures are not sufficient to constitute stimulus differences; something more is required. Davidson *et al.*(4) used Szondi's pictures as well as those of "normals" and found that both group and individual normative reactions could be established reliably for the selection of likes and dislikes. This rather basic research frequently appears as incidental material in many other studies.

Rabin(16, 17) went further by showing that the pictures have meaning in terms of differences in personality characteristics attributed to the pictured individuals. He found that even naive undergraduates could identify some of the diagnoses of the pictured individuals significantly better than chance (16). The ability to identify the diagnoses seems to be related to the amount of training and experience one has had in clinical psychology. This is shown in his original study comparing undergraduates with clinical psychologists in their ability to identify the diagnoses(16). This was confirmed in a later study in which he showed that undergraduates improved in their ability to make these judgments after completing a quarter of standard course work in abnormal psychology. Rabin concludes that Szondi's physiognomic stereotypes are borne out for some diagnoses. Holt(12) used a procedure much like Rabin's and obtained similar findings. Klopfer(14) found a partial confirmation of these stereotypes by asking a group of students to match the pictures and a group of

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personality descriptions based upon each of the 8 diagnoses.

Differences in the stimulus aspects other than the physiognomies occupied the interest of Blessing *et al.*(1). The incidental features that were equated for all pictures in a control series in order to study their effects were clothing, nature of the borders, and intensity of the backgrounds. Considerable influence of these incidental features was disclosed for some of the diagnostic categories. They conclude "—that incidental features as defined do exercise some influence in determining the choices of some factors, and that the rationale of the Szondi test should be modified and qualifications made to allow for these influencing factors."

Fundamental to the application of Szondi's pictures is the belief that they offer optimum stimulus cues for the evaluation of personality. It must be borne in mind that his European mental patients represent a very restricted sample of all possible stimulus pictures. As mentioned above, Davidson *et al.*(4) used stimulus pictures of normals but they do not seem to draw any conclusions regarding the relative superiority of the Szondi pictures over those of normals. Guertin(9) compared the Szondi pictures with those of normal Americans to see which ones showed the better stimulus values. The measure of stimulus value used was *discriminating power* adapted from item analysis procedure. The best pictures for evaluating individual differences would be those that would show the greatest variability when the 48 pictures are ranked for preference value by a group of subjects with heterogeneous personalities. If all subjects tended to rank a given picture about the same, then the picture would be useless in separating individuals in the group. Even though there were wide personality differences among the subjects, the picture under consideration would not discriminate between them. He found that the stimulus cues of the "normal pictures" seemed to interact with personality differences to produce as wide dispersions of rankings as did the Szondi pictures. The best picture of all was from the normal set and it showed a dispersion value twice as great as the largest one for the Szondi pictures. It would appear that the Szondi pictures fail to demonstrate their superiority as stimuli for evaluating personality differences.

Clearly, the Szondi pictures (as well as others) have some psychological importance to subjects. They tend to react to the pictures in terms of personality characteristics attributed to the pictured individuals. Whether these characteristics are based upon stereotypes or more personal habit-patterns has not been clarified, but this point does not seem crucial to Szondi theory. Nevertheless, one might expect that cultural differences would result in the assignment of different personality characteristics to the pictures. It would seem legitimate to question the application of this European-derived test to American subjects, and that a wider population of stimulus pictures could be drawn upon to advantage in establishing stimuli for evaluating personality. A test can be no better than its items (stimulus pictures). Evidence for the superiority of the Szondi pictures over others has not been forthcoming.

Need-Systems

Szondi's need-systems should represent the fundamental parameters of personality rather adequately if this test and interpretive framework are to be adopted in personality evaluation. It is not unreasonable to expect Szondi's factors to be relatively exclusive of one another and to include most personality characteristics within the 8 factors.

Guertin(8) found that certain individual differences were operating in the Szondi test but yet were not represented by the Szondi factors. This was concluded from the fact that, upon Szondi retesting, subjects almost always chose the *same* picture in a given category as on the prior administration. According to Szondi theory, the only requirement is that they select the same number from the category. Borstelmann and Klopfer(2) presented the Szondi pictures in reordered sets and found that the reaction to many pictures was determined largely by "peripheral and cultural cues" characteristic of the individual pictures. Wallen(19) utilized an interesting design to see if the pictures within a given diagnostic group exhibited fairly consistent personality characteristics. He had judges attribute traits to various pictures. These ascribed traits cut across diagnostic categories quite drastically.

By a regrouping of some of the pictures without regard for diagnosis, but rather by observing the tenseness of facial musculature, he was able to get consistency in the assignment of traits.

A rather crucial study and one with wide implications is a factor analysis of some of the Szondi pictures made by Guertin(10). Two pictures of each diagnostic category were intercorrelated in a preference-ranking experiment and the resulting matrix was factor-analyzed. One would hope to find 8 separate factors each with heavy loadings for a different diagnostic category. However, only 5 factors were revealed, which did not seem to bear any relationship to the individual diagnostic categories. The conclusion reached was that "the factor constitutions of pictures of the same diagnostic category are no more similar than those of pictures from different categories." In view of these results it would seem that Szondi has failed to establish exclusive factors that are useful in describing behavior. Since only one picture of those studied seemed to be loaded with primarily one factor—a so-called "pure" item—it was suggested that a multiple-correlation technique would seem to be a more suitable method for analyzing test results and arriving at factor loadings of the subject's personality.

The results of this factor analysis that was reviewed suggest that Szondi has established his need-systems on sand. One must consider the various "meanings" of a given picture for different individuals. One person might react to the absence of clothes in a picture, while another might react to the age of the individual, etc. Two or more such stimulus aspects may, and probably do, operate for a single subject to determine his choice. The pure, unambiguous picture seems quite rare and Szondi's interpretive method (need-systems) depends upon this to a great extent. It is unfortunate that any procedure as complex as determining the basic parameters of personality (need-systems) was based upon such an intuitive method.

Technical Design

Harrower(11) comments upon the difficulties encountered with Szondi testing because of its being a forced-choice technique. Specifically, she mentions that if a subject has a serious imbalance showing in one or two factors then another almost as serious imbalance does not appear because the number of choices is restricted. Rabin and Guertin(18) have discussed the Szondi test from the point of view of its being a forced-choice technique. This study paid particular attention to the necessity of having pictures placed in homogeneous sets according to preference value. It is seen that the Szondi sets seem to take this into consideration somewhat but not to a sufficient degree. Regrouping of the pictures into homogeneous sets for testing with college students is suggested in this article. Such revisions would tend to reduce the distortion of choices that tends to exist in the present grouping.

Need-Systems and Empirical Variables

Harrower(11) presented a mass of statistical tabulations derived from Szondi testing of normals, neurotics, and psychotics. It is unfortunate that the material is not reduced to fewer statistics in order to simplify analysis for the reader. Without such analytic simplification the author seems to have found it difficult to draw conclusions.

Guertin's study(7) seems to lend some general support to Szondi's need-system framework. He found that subjects with personality imbalances tended to show factor imbalances also, when compared with control profiles obtained by chance selection of Szondi pictures. Likewise, "forces other than chance were found to be operative in picture selection" in David's study(3) of paranoid schizophrenics. Both of these studies demonstrate that chance was not operating alone in determining picture selections but do not present convincing evidence that important personality variables are responsible for preferences, since cultural aspects of the pictures might prove the determining factor.

In his study of paranoid schizophrenics(3) David also found that Deri's statement, "the most characteristic reaction for patients with identical diagnoses with the particular stimulus pictures of the given factor is that the greatest variability is found in the factor corresponding to their own diagnosis," was sub-

stantiated. Details were not available in this brief report but no mention was made of a control group of normals, who might conceivably also show greatest changes in the paranoid factor (and Ego vector). Paine (15) also was interested in profile changes in psychotics. His attempt to find greater changes from administration to administration for the psychotics than for normals was unsuccessful. Furthermore, he was unable to find any relationship between Szondi profile changes and alterations in the patients' behavior on the ward.

Paine(15) concentrated particularly upon the meaning of open reactions (no choices within a diagnostic category). Since Deri(5) postulates that open factors are associated with prior behavioral discharge, Paine investigated this idea. His conclusion was that open factors did not seem to be related to behavior, but rather appeared independently of behavior. Fosberg(6) used a clever design to provide behavioral discharge of hypothesized tensions in order to study the effect on the draining of factors. The paroxysmal vector (epileptic and hysteric) was studied by observing changes in profiles after shock treatment. He failed to find a significant difference in open reactions before and after shock but used only 5 cases. However, he did take 5 pre- and 5 postshock records making a total of 50 records in each group for his statistical examination. Twenty normal married men and women took the Szondi 5 times within 12 hours of coitus, and 5 times after 48 or more hours had elapsed since coitus. Again no significantly greater draining was observed for the sexual vector. These conclusions, were, of course, based upon 100 records under each condition. The author concludes, "Szondi theory of decrease in selection of specific vector cards (pictures) with discharged tension in such areas is not substantiated."

Unfortunately Holt's paper(13) was not reviewed but a fairly complete abstract indicates that he studied changes in the Szondi with changes in attitudes and subjective feelings of a single individual. "Numerous correlations (.7 and larger) were found between fluctuations in the Szondi choices and fluctuations on other tests." For example, he reports a correlation of .79 between an affirmative answer to "I seek sexual experience whenever possible" and the loading for *h* (homosexual factor). This is a very interesting technique but fraught with statistical pitfalls.

Relatively few direct validations have been reported. Some have been reported to have been in progress for some time and one cannot help wondering if rather negative results are not being withheld. However, such procedures are very difficult and it is just as likely that methodological difficulties have led to the abandonment of some of these projects. David(3) states, "Results based upon Szondi's method of structural analysis agreed with staff diagnosis in 88% of the cases" for his group of 50 paranoid schizophrenics. The report is so brief that the reader is left in doubt as to what constituted agreement. Yet one is surprised to learn of such amazingly high correlation since all the minor studies cited have indicated weaknesses in the Szondi test.

With the exception of two investigations, the details of which were not available to this reviewer, research has failed to disclose relationships between test behavior and empirical variables. While there is contradictory evidence pointing to the need for more complete evaluation, it would seem safe to say that some of Szondi's and Deri's theoretical statements must be regarded with question. This is particularly true with respect to the meaning of open reactions and profile changes.

Conclusions

This review has been rather superficial in the interest of preserving the aim of the paper: to present a summary and integrated perspective of Szondi research. No review can be a substitute for a thorough examination of original sources. On the other hand, some general criticisms should be made of the design of these studies.

Without becoming picayunish about statistics it might be pointed out that most of the statistical techniques employed in the experiments reported are approximate only. This is a consequence of the lack of a meaningful scale in test results and the skewing of data that results from forcing preferences onto

such a narrow scale. Chi-squares are to be recommended highly in the analysis of the sort of data relating to the factor loadings. The calculation of correlation coefficients in any fashion except through dichotomies will result in coefficients with little meaning.

Probably the criticism that fits all Szondi studies is that they are not crucial tests of the Szondi test itself. It hardly can escape the reader that all studies have nibbled on very small aspects of Szondi theory and application. No large-scale, sound validation attempt has come to the reviewer's attention. This would be the ultimate test of the pudding. It is well recognized that good validations are difficult because of the unreliability and invalidity of the criteria, as well as the difficulty encountered in transporting test results and criteria into a common language or frame-of-reference. This may account for the conspicuous absence of such studies. On the other hand, there has always been a certain scepticism about the value of this new test and investigators have gone slowly in their attacks on the problem before investing the time and money demanded by such a project as would be necessary to produce a convincing validation. This concentration upon smaller aspects of a system also indicates a methodological sophistication that is coming to the fore in all areas of research. The checking of deductive implications of postulates, as seen in the Szondi research, offers a convenient attack on problems that are inconvenient to handle in gross ways.

Certain value accrues to this piecemeal, deductive examination of the Szondi technique. Rather than rejecting the test completely, should validation attempts fail, it begins to seem possible to salvage the general technique. Through the study of the Szondi pictures much has been learned about the evaluation of personality through preferences for pictures. The factor analysis reviewed here revealed 5 independent factors from the consideration of 15 Szondi pictures. It seems likely that with new, carefully selected stimulus pictures presented in a well-designed forced-choice manner valuable information about a subject's personality can be obtained. When such information is treated in a multiple-correlation fashion with an empirically derived (factor analysis) frame-of-reference a valuable test of personality may become available.

BIBLIOGRAPHY

1. Blessing, H. D., et al. An experimental investigation of some incidental features of the Szondi Test. Am. Psychol. (cited), **5**: 490, 1950.

2. Borstelmann, L. J., and Klopfer, W. G. Do the Szondi choices reflect individuality? Am. Psychol. **5**: 470, 1950 (Abstract).

3. David, H. P. (Preliminary project report.) Szondi Newsletter (mimeographed by University of Nebraska), 1, 1949.

4. Davidson, W. N., et al. Experimental analysis of the Szondi Test. Am. Psychol. **4**: 388, 1949 (Abstract).

5. Deri, Susan. Introduction to the Szondi Test. New York: Grune and Stratton, 1949.

6. Fosberg, I. A. A study of the sensitivity of the Szondi Test in the sexual and paroxysmal vectors. Am. Psychol., **5**: 326, 1950 (Abstract).

7. Guertin, W. H. A consideration of factor loadings on the Szondi Test. J. Clin. Psychol., **6**: 262, 1950.

8. Guertin, W. H. A test of a basic assumption of the Szondi Test. J. Consult. Psychol., **14**: 404, 1950.

9. Guertin, W. H. A comparison of the stimulus value of Szondi pictures and those of normal Americans. J. Clin. Psychol., **7**: 163, 1951.

10. Guertin, W. H. A factor analysis of some Szondi pictures. J. Clin. Psychol. (In press).

11. Harrower, Molly. Experimental studies with the Szondi Test. Am. Psychol., **5**: 485, 1950 (Abstract).

12. Holt, R. R. (Preliminary report on a project.) Szondi Newsletter, 1, 1949.

13. Holt, R. R. An approach to the validation of the Szondi Test through a systematic study of unreliability. Am. Psychol., **4**: 269, 1949 (Abstract).

14. Klopfer, W. G. An investigation of the Szondi Test by the association method. Am. Psychol., **4**: 269, 1949 (Abstract).

15. Paine, H. E. Association of measurable changes in Szondi Test profiles with measurable factors in behavior of psychotics. Am. Psychol., **5**: 481, 1950 (Abstract).

16. Rabin, A. I. Szondi's pictures: Identification of diagnoses. J. Abnor. Soc. Psychol., **45**: 392, 1950.

17. Rabin, A. I. Szondi's pictures: Effects of formal training on ability to identify diagnoses. J. Consult. Psychol., **14**: 400, 1950.

18. Rabin, A. I., and Guertin, W. H. The Szondi Test as a forced-choice technique. Paper read at the 23d annual meeting of the Midwestern Psychological Association, Chicago, 1951.

19. Wallen, R. Factors affecting the choice of certain Szondi Test pictures. Paper read at the 22nd annual meeting of the Midwestern Psychological Association, Detroit, 1950.

PSYCHIATRIC OBSERVATIONS UNDER SEVERE CHRONIC STRESS[1]

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Individual and mass reactions to acute and chronic stress have been studied intensively in recent years. Adler(1, 2) and Tyhurst(3) reported on the reactions of civilians in acute disasters. The reactions of military personnel both to acute and chronic stress have been investigated by Grinker and Spiegel(4), Swank(5), and others. Several authors reported on psychological observations from internment and concentration camps during, and after, World War II(6-10). These latter reports have lent support to psychiatric concepts of a more general significance(11), particularly regarding the pathogenesis of schizophrenia(12). It may, therefore, be interesting to report on the actual course of the psychoses and neuroses in an internment camp and to compare these observations with reactions of normal people in the same camp. Some observations will be added concerning the reactions that several of the former internees showed after the liberation and their return home.

The camp in question was a little town in Northern Bohemia, Theresienstadt (Terezin). Founded in 1780 as an Austrian fortress against the Prussian army it has kept its character as a stronghold and was still surrounded by ramparts and trenches. It was for that reason that Theresienstadt was chosen as an internment camp for Jews from Central Europe and served this purpose from November 1941 until the end of the war. There were 139,666 people of both sexes and all ages sent to Theresienstadt; 33,468 died there, 86,862 were sent east to other camps in Poland, the rest stayed in Theresienstadt until the liberation.[3] Although the incoming and outgoing transports created a constant fluctuation the population present, at any given moment, averaged 30,000 to 40,000 people.

Material living conditions were poor. The food allowance averaged 1,400 calories for workers (every man and woman between 14 and 65 years of age was forced to work) and considerably less for nonworkers. Clothing was utterly insufficient, living space confined to approximately 2 sq. metres per person, 50 to 60 people to a small room. With few exceptions men and women lived in separate barracks, any contact being forbidden. Hygienic facilities were practically nonexistent. Epidemics of various infectious diseases raced through the camp and took the lives of thousands of persons. Diseases from nutritional deficiency were prevalent.

Perhaps of greater importance were the psychological factors. The humiliation of an imprisonment without any objective or subjective guilt, the impossibility of changing one's fate no matter how one behaved, the deprivation of any gratification of the vital drives, the complete lack of privacy, the forced labour and, above all, the constant danger of being sent east to an unknown but certainly worse destination exerted constant severe stress.

Although in general the internment camp of Theresienstadt was not essentially different from other similar camps in Europe, there were two features that distinguished it from most of the others. Right from the beginning a kind of autonomy was established among the internees, administered by a council of elders. Although this autonomous administration could not change the living conditions, nor the forced labour, nor the transports to Poland, it had a considerable psychological effect on the internees. The cultural patterns and ties were not completely destroyed, social order could be preserved, and the ruthless struggle for survival, so common in other camps, could be prevented. Important also was the fact that the camp was provided with an extremely efficient health service, built up by, and composed solely of, internees. The former army hospital served

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[3] Between April 20 and May 5, 1945, 12,786 prisoners from other concentration camps were brought by rail or on foot to Theresienstadt. They are not included in the following considerations.

as a general hospital. It had the usual departments including outdoor clinics and a psychiatric and a neurological unit. There were other hospitals for special purposes. A modern autopsy room, in the crematorium, was built by the internees. However, bacteriological and serological investigations were not allowed. The specimens had to be sent to Prague, and the results came back with some delay, which was unfortunate with regard to the various epidemics.

There were 583 doctors and 1,583 nurses who worked in their profession for various lengths of time during the years of the camp's existence. They tried to apply scientific standards in diagnosis and therapy in spite of constant stress and limited means. However, 80% of the doctors and 83% of the nurses were sent east eventually.

These remarks seem necessary to understand the fact that in Theresienstadt clinical observation of the sick was possible, as well as autopsy of interesting cases.

Before turning to the observations of mentally sick patients it seems necessary to describe briefly the behaviour of "normal people." As in other camps nearly every adult newcomer experienced an initial shock, the severity and duration of which was rather uniform in the average adults of both sexes. It was characterized by an emotional change, a state of depression and retardation, loss of initiative even for the simplest tasks of everyday life—like eating and washing—and accompanied by anorexia, sleeplessness, constipation, and, in most of the women, loss of the menstruation period, which took place instantly after their arrival in the camp. Serious incidents, however, like suicidal attempts or panic reactions were not observed. Many people experienced at the same time a feeling of detachment and unreality, as if they lived in a surrounding of ghosts and were only spectators of events that had no real bearing on themselves. Similar observations have been reported by Bettelheim(7). After an average of one or two weeks the initial phase subsided without any treatment. It was remarkable, however, that children and adolescents did not experience this initial depression whereas old people were not able to overcome it. It was mostly in these old people that the initial phase slowly changed to a state of deep apathy.

Adaptation to the conditions of the camp life set in slowly and was achieved gradually over a period of months. Thousands of internees were sent east before they could become adjusted. Although the wish to survive, to stay healthy and able to work in order to avoid transportation east, was strong in all, the capacity for adaptation varied with different groups, and individuals. Several factors, constitutional, psychological, and environmental, appeared of importance both for the speed and the degree of adjustment ultimately achieved.

One of the most important factors was age. Children and adolescents became adjusted quickly and completely. Old people, on the other hand, never became adjusted. They stayed in a state of apathy and indifference and had to be cared for, even when not manifestly ill. Nevertheless the natural sequelae of this psychic condition, uncleanliness and infections, could hardly be avoided. Together with starvation and deficiency diseases they caused the death of thousands of these old people.

Women, in general, became earlier and often better adjusted than men. The level of intelligence was not of such decisive importance as other personality features in determining capacity for adjustment to the camp situation. It could be observed over and over again that people educated to fairness in dealings with their fellow men and trained to control their emotions and drives became earlier and better adjusted than others of higher intelligence not so trained. This observation is in agreement with the experience of Bondy(8) in another camp that previous character forming enables people to withstand extremely difficult situations.

Religious people of various denominations, particularly priests, became adjusted quickly and efficiently. This was true also for the members of certain professions who were allowed to work in their own way, and for the sake of others, like doctors and nurses. But it was not solely the wonted type of work that sped up their adjustment. The external urge to work itself had, to some extent, a beneficial effect in this respect regardless of the kind of work the internee performed. It could be observed that people who managed to avoid working could not adjust and had to

suffer, in the long run, more than their fellow prisoners.

It was mentioned earlier that the level of adjustment achieved was different with different people. For the average internee adjustment meant to become accustomed to the hardships of the new life, to sustain hunger and forced labour and to stay clean in order to avoid, as far as possible, contamination with the various infectious diseases in the camp. These men and women responded to the rules of the camp, they worked according to the orders of the authorities, but they never could completely accept the camp as a reality. They frequently boasted about their past positions in civilian life and they spent considerable time in individual and group day-dreaming. They never became a spiritual or material help to their fellow prisoners.

On the other hand, there was a group of men and women who adjusted themselves so quickly and effectively that they became a great help to the others. These people lived and worked under abnormal conditions, but they accepted these conditions as a given reality; they tried to forget the better past and not to indulge in fantasies about the future. Doctors and nurses, but not only these, were among the best adjusted people.

Regardless of the degree of adjustment achieved, its effect was modified, impaired, and diminished by the well-known sequelae of starvation and the complete lack of all essential vitamins(13-15). In the intellectual sphere, a memory defect, particularly for recent events, developed, noticeable even in adolescents, marked in adults, but most severe in elderly people. With them it would lead to a serious impairment of orientation particularly at night when combined with frequent hemeralopia. Another intellectual impairment concerned the capacity for attention and concentration. Although noticeable in nearly every prisoner it was of particular importance with manual workers handling sharp and heavy tools. Severe injuries, easily avoidable under normal conditions, occurred because of this lack of attention and concentration.

In the emotional and volitional sphere two main symptoms became apparent with any prolonged stay in the camp: indifference and even apathy especially in older people, and irritability leading occasionally to severe temper outbursts. The former caused the constriction of the horizon and interests generally observed in all internment camps. It was characteristic that serious matters like the death of relatives or near friends often met with only a very superficial sympathy, whereas trifles and small quarrels, occurring and unavoidable in the overcrowded rooms and lineups for food, would lead to severe temper outbursts that sometimes required the active intervention of the authorities. An interesting aspect of the indifference of the prisoners was the fact that thousands of them could be shipped east at one time by 10 S.S. men without a trace of resistance. It was because of this indifference and inadequate emotional reactions that Utitz(16) spoke of *"Schizothymisierung"* in Theresienstadt.

The main interest of the internees, with some exceptions, was the problem of food. It governed their thoughts not only so far as reality was concerned but occurred also in their day- and partly in their night-dreams. The sexual drive and interest, on the other hand, became more and more reduced with lengthening stay in the camp, particularly among the hard-working men and women. Nevertheless it was not completely missing. Some pregnancies even occurred, which had to be interrupted by order of the S.S. authorities.

It should be mentioned, however, that there was another topic that could break this indifference, at least in the younger adults: political rumours, based solely on news reports from unreliable channels, were believed and spread without any criticism. People who dared to express some doubts were abused and occasionally even attacked by their irritable neighbours.

The mental state of the average, fairly adjusted prisoner after several months of internment can therefore be characterized by impairment of memory and concentration, constriction of the mental horizon, indifference, and irritability. As a group they showed a definite tendency to uniform behaviour on a primitive level. The physiological changes of starvation and avitaminosis could be observed in the somatic sphere: loss of weight, lowering of blood pressure and pulse rate,

œdema of the face and lower extremities, polyneuritis, and the many other deficiency diseases like combined sclerosis of the cord, hemeralopia, xerosis corneæ, etc. That was the background against which the psychoses have to be considered.

To assess the over-all number of psychotic patients in Theresienstadt presents greater difficulties than anywhere else mainly because of the fluctuating population. However, the relative admission and population figures of the psychiatric unit of the general hospital would permit us to reach some conclusions. It is interesting to note that the admission figure was extraordinarily high as compared with normal conditions. It amounted to 1% from 1941 until the second half of 1943 when it dropped to about 0.6%, where it remained till the end of the war. The average population of the psychiatric unit, on the other hand, during the years 1941-45 centred around 0.1%. Both admission and population figures therefore follow a trend quite opposite to that usually found in mental hospitals under normal conditions. The Statistical Report of the Dominion of Canada for 1947(17), for instance, shows a relative population of the mental hospitals of 0.4% and an admission figure of only about 0.11%. Compared with normal conditions Theresienstadt's psychiatric wards therefore show an extremely high admission and an extremely low population figure.

In the beginning of its existence as an internment camp hundreds of mentally ill patients from various psychiatric institutions in Central Europe were sent to Theresienstadt and were brought directly from the station to the psychiatric wards. They stayed there for various periods ranging from 1 to 2 days to several months and were then sent further east. This policy went on for nearly 2 years. It was not until the second half of 1943 that these mass transports of psychotic patients to Theresienstadt stopped, as reflected in the drop of the admission rate to 0.6%.

Another cause of the high admission rate was the fact that the difficult living conditions prevailing in the camp made it necessary to commit to the psychiatric wards many patients who, under normal conditions, could have lived with their families, although the doctors tried to commit as few patients as possible to spare them the transportation east.

The low population figure of the psychiatric unit is explained by the fact just mentioned that the psychotic internees were sent east to extermination(18). It therefore became the policy of the psychiatrists to treat the patients as energetically as possible in order to discharge them before the next transport.

Unusual and completely abnormal conditions prevailed also as far as the diagnostic distribution of the patients was concerned. Whereas under normal conditions senile dementia constitutes about 9-10% of the admissions of mental hospitals(17, 19), this condition occupied, with 40% of new admissions, the first place on the psychiatric wards in Theresienstadt. This was partly due to the original designation as an old people's camp where people of more than 60 years of age made up nearly 50% of the population. Furthermore, the nutritional deficiency accelerated and aggravated the clinical manifestation of senile dementia particularly the memory impairment and disorientation, perhaps the atrophy of the brain itself. Other factors added to the early manifestation of senile dementia. The sudden imprisonment, the strange environment, the overcrowded rooms with the complete blackout at night, the constant noise of hundreds of voices, the continually changing neighbours, the lack of familiar faces, made the senile impairment of orientation in space soon apparent. The lack of newspapers, calendars, radio apparatus, and even watches (only doctors, nurses, and administration officers were permitted to have watches) accelerated and aggravated the disorientation in time. The many somatic diseases and frequent injuries probably also precipitated the senile psychoses. Doctors and administrators jointly tried to keep as many senile patients as possible out of the psychiatric wards and to manage them in the usual camp environment. Nevertheless the social conditions were stronger.

The symptomatology and course of the senile psychoses in Theresienstadt were the same as found under normal conditions. There was no unusual and specific feature added nor were any of the usual signs miss-

ing. However, many of our senile patients showed signs of combined sclerosis of the cord as a sequela of starvation, and the lack of food and many drugs led to an early death of those patients who were not sent immediately to Poland. Mortality was 100% among the senile patients.

Interesting was the fact that psychoses due to cerebral arteriosclerosis were encountered only rarely. Cerebral vascular accidents and postapoplectic psychoses were rare. This held true both for cerebral hemorrhages and, surprisingly enough, also for thrombotic infarctions although the blood pressure was generally decreased. The starvation diet apparently had a beneficial effect on arteriosclerosis in general and on cerebral arteriosclerosis in particular. Arteriosclerotic dementia, on the other hand, may often have been misdiagnosed as senile dementia. The differentiation of both conditions was even more difficult in Theresienstadt where the somatic signs of the former were less pronounced than under normal conditions.

General paresis was extremely rare. Only 3 patients suffering from that disease came on the psychiatric wards; a fourth one, a case of taboparesis, was detected and diagnosed in the outpatient clinic but was sent east before being committed to the ward. The G. P. I. cases were treated with pyrifer and arsenicals. Malaria was not available and penicillin unknown. Alzheimer's and Pick's disease were not encountered or not diagnosed.

Epilepsy posed no problem. The hunger diet apparently prevented many known epileptics from having seizures. Moreover, difficult patients became manageable. It was not necessary to commit these patients to the psychiatric wards. They worked, or at least lived, with the general population, easily controlled by luminal, hydantoines, or bromides.

The endogenous psychoses were also found in frequencies quite different from those encountered under usual conditions. Schizophrenia was relatively rare as compared with normal conditions, probably because more than 70% of the internees were over 30 years of age, that is, over the average age of onset of schizophrenia. But there were, nevertheless, schizophrenic breakdowns occurring in the camp. All of them had to be committed to the psychiatric wards, where they constituted about 10% of the new admissions. This figure certainly is not higher, as could be expected regarding the distribution of the population, and does not furnish any proof for the assumption that apathy and indifference in the concentration camps caused schizophrenia.

Symptomatology and course of schizophrenia were not different from the usual findings, but therapy was of necessity particularly unsatisfactory because of the shortage of insulin for psychiatric purposes. Most of the patients were, therefore, treated with metrazol or with pyrifer fever therapy. The results of these therapeutic measures were limited. None of the patients was discharged and all were sent east.

Manic-depressive psychoses, on the other hand, were more frequent than usually found under normal conditions. They constituted about 25% of the admissions. This perhaps may be due to a higher incidence of this disease among the internees(20). It was surprising to note that reactive depressions, apart from the common initial depression of the newcomers, were missing in Theresienstadt despite the sad conditions in the camp, and in spite of the suffering from losses of relatives and friends. Whether this was the case because of the emotional indifference that supervened with extended stay in the camp or whether the suffering and the humiliation of the internees atoned for their guilt feelings remains a matter of speculation.

It is in line with this observation that among the manic-depressives very often the first or even the only phase observed was a manic reaction. However, depressive phases were encountered frequently and the same was true for the depressive or for depressive-paranoid psychoses of the involutional age. They constituted 10% of the new admissions. This figure, although higher than under normal conditions, was in accordance with the age distribution of the population. It seems interesting to note that the impairment of sexual function, with accompanying amenorrhea occurring in nearly all women after internment, did not cause any psychotic manifestations.

The symptomatology and course of these psychoses did not differ from the usual pic-

ture. Treatment consisted of metrazol shocks in depressive psychoses with the usual good results. Manic states were treated with sedation. Many of these patients could be saved from transportation through energetic treatment and quick discharge from the psychiatric wards.

Apart from the psychiatric diseases usually encountered in mental hospitals, there were some psychoses specific for an internment camp. Apart from the milder forms of memory defect due to severe malnutrition common to all internees and aggravated in the senile age group, there were several cases of severe Korsakow's psychosis with polyneuritis and/or combined sclerosis of the cord in nonalcoholic younger adults. These Korsakow psychoses started insidiously after a longer stay in the camp. They were sometimes precipitated by an infectious disease, such as typhoid fever, and remained unimproved during the whole period in camp although therapy with thiamine chloride and nicotinic acid was instituted and carried out for a considerable time. It may be, however, that the dosage used was not large enough, owing to the small amounts available.

There were, on the other hand, a few cases of confusional psychoses connected with diarrhœa and pigmentation of the skin that responded well to the therapy just mentioned. It was concluded therefore that these cases belonged to the group of pellagra psychoses with a good outcome.

An unusually high percentage of admissions, namely about 5%, were psychoses due to infectious diseases. Typhoid fever and acute encephalitis were the two main causes. In both instances the only cases that were transferred to the psychiatric wards were those who became completely unmanageable in the infectious department. Therefore the cases committed constituted only part of all cases who actually showed psychopathological symptoms. The typhoid psychoses were characterized by the well-known delirious states with disorientation and hallucinations. The encephalitic psychoses were partly of the same type. Other cases were characterized by acute anxiety states, which subsided together with the neurological signs(*22*).

Our observations seem interesting not only because of the positive findings but also because of the absence of certain diseases usually found in psychiatric hospitals. Epilepsy was mentioned above as very rare. Alcoholism and addiction to barbiturates were not encountered. But there were several cases of morphinism among doctors who had been addicted before being sent to Theresienstadt. How they managed to obtain the drug in the camp, where it was kept under the strictest control, could not be completely cleared up. They were committed, in spite of the danger of being sent east, because they constituted a public danger in draining the small amount of morphine available for common use. Treatment consisted in gradual withdrawal with the help of glucose and B_1 injections. More important was the fact that after discharge every case was strictly and effectively supervised and watched, which was possible only under that particular regime. There were no relapses.

Mental deficiency, which usually constitutes a high percentage of admissions in mental hospitals, was rare in the psychiatric wards though not in the population of the camp. Except for very few cases of idiocy or severe imbecility, no mentally defective patients were committed. They worked as labourers with the other internees and did not cause any difficulties that would have necessitated their commitment. A few were handled directly by the German authorities. This was the case when mental defectives, in a short circuit reaction, decided to get rid of the hardships of the camp and tried to escape. These attempts were so primitive and conspicuous that the persons concerned were always captured. They never returned to the camp. Their fate remained officially unknown.

Psychopaths, on the other hand, however emotionally unstable never tried to escape. Most of them adjusted themselves fairly well, some even became workers for the autonomous authorities. Others, of course, caused quarrels and arguments with their fellow internees or with the autonomous authorities but they usually knew well enough where to stop—before they endangered themselves. Many of them managed, in some way or other, to avoid being sent east and to stay in Theresienstadt till the end of the war.

One of the most interesting observations

the clinician could make in Theresienstadt concerned the problem of neuroses. Many patients were known to the psychiatrists from prewar times as suffering from severe and long-lasting psychoneuroses such as phobias and compulsive-obsessive neuroses. These neuroses either disappeared completely in Theresienstadt or improved to such a degree that the patients could work and did not have to seek medical aid. Moreover, no new cases of psychoneuroses developed in the camp. Similarly, diseases in the etiology of which the psychic factor usually plays an important role were extremely rare. This holds true for colitis mucosa, gastric ulcer (except for some cases of gastric ulcer developing in the course of encephalitis), bronchial asthma. It furthermore became apparent how important the psychic factor seems to be in everyday diseases. The number of common colds, for example, was negligible despite the fact that the internees were insufficiently dressed and had to spend hours in the open regardless of the weather working or lining up for food. As these observations could be made even with newcomers, in whom indifference had not yet developed, it would appear that the severe hardships of life as encountered only in extreme situations can ameliorate or prevent psychoneuroses and psychosomatic diseases.

A few hysterical reactions, seizures, pareses, and demonstrative suicidal attempts were observed occasionally when transports were being sent east. They tended to save some patients from the transport, but not in the majority of cases.

However, several neurotic and psychotic reactions could be observed after the liberation. Unlike other internment camps, liberation in Theresienstadt was not accompanied by any elation of mood. It was at that time that a severe typhus epidemic broke out that attacked more than 2,500 people. Several hundreds died.

It was not until the survivors of the camp returned to their respective homes that neurotic reactions developed. It should be mentioned, though, that most of the Theresienstadt prisoners adjusted quickly and smoothly to the normal conditions. However, no systematic large-scale observation and statistical evaluation was possible; only the personal experiences of the author can be mentioned. It was interesting to note that many of these neurotic patients, who had returned either directly from Theresienstadt or from other camps where they had been sent earlier during the war, refused to see psychiatrists to whom they were referred by their physicians. They claimed they had no confidence in doctors who had not undergone the same hardships. Therefore the very few psychiatrists who survived and reopened their practices were crowded with former fellow internees seeking their help.

The psychiatric condition of some patients was a reactive depression of considerable severity with some peculiarities due to the situation of the patients. A strong feeling of guilt for having survived where the relatives and friends succumbed was one of the outstanding symptoms. In some cases this feeling of guilt was concealed behind the grief of not being able to find the graves of the beloved persons. In other patients anxiety neuroses developed with many hypochondriacal complaints, mostly concerning the heart and lungs, such as fears of incurable tuberculosis. These reactions, however, occurred, as a rule, only after several months when the real somatic ailments the patients had brought from the camps had already subsided and when they were supposed to resume their work. This observation is in agreement with the experiences of Symonds (21), Adler(2), and others on posttraumatic neuroses.

Therapy of these conditions was not too difficult, except for one condition the etiology of which could not be cleared up completely: the sexual impotence observed in several young men. Neither psychotherapy alone nor hormones nor the combination of both proved very effective.

Several months after their return some of the old neurotics who had been free of complaints during their stay in the camp again developed their former symptoms. Fortunately not all of them became ill again; some stayed healthy, at least during a 4-year observation period.

Endogenous psychoses were observed in several of the returning internees at various intervals after the liberation. Whether these psychoses were precipitated by the loss of

relatives and friends and the necessity of building up a new existence, or whether they occurred independently of these factors, is difficult to state. Clinically, these cases did not show unusual features either in their symptomatology or in their course and reaction to treatment, although in hallucinations and delusions of some of the patients elements of the former life in the camp did occur.

SUMMARY

The reactions and behaviour of the internees of the internment camp, Theresienstadt, are described. They were characterized by remarkable uniformity. Every adult internee experienced an initial phase of reactive depression. Although the capacity for, and the degree of, adjustment to camp life varied with different people the final outcome of the adapting process became uniform again owing to the physiological and psychological sequelæ of the constant and severe stress.

The incidence and course of the various psychiatric conditions occurring in the camp are discussed. No influence of the life and conditions in the camp on endogenous psychoses could be observed. Senile dementia and other organic psychoses, on the other hand, were influenced to a considerable degree.

No new cases of psychoneuroses originated in Theresienstadt. Old and long-lasting conditions of that kind improved to such an extent that the patients could be considered as practically cured. After the liberation, however, neurotic reactions could be observed in some of the former internees.

BIBLIOGRAPHY

1. Adler, A. Neuropsychiatric complications in victims of Boston's Cocoanut Grove disaster. J. A. M. A., **123**: 1098, Dec. 1943.

2. Adler, A. Two different types of post-traumatic neuroses. Am. J. Psychiat., **102**: 237, Sept. 1945.

3. Tyhurst, J. S. Psychiatric Study of Disaster. Lecture before the Psychiatric Section of the Montreal Medico-Chirurgical Society, January 16th, 1950.

4. Grinker, R. R., and Spiegel, J. P. Men Under Stress. The Blakiston Company, Philadelphia. 1945.

5. Swank, R. L. Combat exhaustion. A descriptive and analytical analysis of causes, symptoms and signs. J. Nerv. and Ment. Dis., **109**: 475, 1949.

6. Bondy, C. Problems of internment camps. J. Abnorm. and Soc. Psychol., **38**: 453, 1943.

7. Bettelheim, B. Individual and mass behaviour in extreme situations. J. Abnorm. and Soc. Psychol., **38**: 417, 1943.

8. Brill, N. Q. Neuropsychiatric examination of military personnel recovered from Japanese prison camps. Bull. U. S. Army M. Dept., **5**: 429, 1946.

9. Friedman, P. Some aspects of concentration camp psychology. Am. J. Psychiat., **105**: 601, Feb. 1949.

10. Friedman, P. The road back for the DP's. Commentary, **6**: 502, Dec. 1948.

11. Greenson, R. R. The psychology of apathy. Psychoanal. Quart., **18**: 290, 1949.

12. Jenkins, R. L. Nature of the schizophrenic process. Arch. Neurol. and Psychiat., **64**: 243, 1950.

13. Bowman, K. M., and Wortis, H. Psychiatric syndromes caused by nutritional deficiency. Research Publ. Assoc. Nerv. and Ment. Dis. **22**: 168, 1943.

14. Hardwick, S. W. The role of vitamin deficiency in nervous and mental disorders. M. Press., **219**: 219, 1948.

15. Schiele, B. C., and Brozek, J. "Experimental neurosis" resulting from semi-starvation in man. Psychosomat. Med., **10**: 31, 1948.

16. Utitz, E. Theresienstadt. Sexl. Continental Edition, Wien, 1948.

17. Mental Institutions 1947. Dominion Bureau of Canada. *XVI.* Annual Report.

18. Wyrsch, J. Die Tötung Geisteskranker. Monatschr. f. Psychiat. u. Neurol., **118**: 305, 1949.

19. Strecker, E. A., et al. Practical Clinical Psychiatry, 6th edition. The Blakiston Company, Philadelphia, Toronto.

20. Henderson, D. K., and Gillespie, R. D. A Textbook of Psychiatry, 4th edition. Oxford University Press, 1936.

21. Symonds, C. P. Anxiety neuroses in combatants. Lancet, **245**: 785, Dec. 1943.

22. Kral, V. A. Beobachtungen bei einer grossen Enzephalitisepidemie. Schweiz. Arch. f. Neurol. u. Psychiat., **64**: 281, 1949.

TOWARD UNIFICATION OF TRAINING IN PSYCHIATRY AND PSYCHOANALYSIS[1]

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As a result of the traditional separation between psychiatric training and psychoanalytic training, one finds 3 categories of psychiatric residents in many psychiatric centers: (1) some residents in training in a psychoanalytic institute concurrent with the latter part of their psychiatric residency; (2) some undergoing a personal analysis with the hope of getting training in a psychoanalytic institute; (3) many wanting training in a psychoanalytic institute, but unable to get either a personal analysis or psychoanalytic training.

How do psychiatric residents feel about this distinction in training? In order to ascertain their attitudes we made a preliminary survey of 42 residents in 2 psychiatric residency training centers, using a questionnaire method. Do psychiatric residents feel handicapped or inadequate in their clinical work when they are not also being trained in a psychoanalytic institute? And we asked those having training in a psychoanalytic institute if it made a significant difference in their understanding and treatment of patients. Their comments had to be evaluated in terms of (1) whether their attitudes reflected the quality of the dynamic training of the specific hospital and clinic, and (2) whether their attitudes reflected personal emotional needs that had become displaced onto the lacks in the training hospital and clinic.

The chief concern of all these residents, whatever their future plans, centered on their wish to develop psychotherapeutic skills. Those who were not in training in an analytic institute felt that they needed organized teaching in psychodynamics and more supervision, but no resident, in or out of analytic training, felt he was getting enough supervision. This is not unrelated to the fact that psychotherapy in itself is both complicated and difficult. Therefore any resident, whatever his training, has both certain realistic limitations and his feelings of uncertainty, for which he hopes more instruction and supervision will compensate.

Of the discontent expressed by the residents, there was less found where there was opportunity either for personal analysis or psychoanalytic training. All the residents, without one exception, who were not in training at a psychoanalytic institute, expressed the hope that they would be able to be. This preliminary survey indicated that residents wanted (1) *psychodynamically sound supervision* in diagnostic, therapeutic, and management responsibilities during their residency program, and (2) *organized courses in psychodynamics* (this they equated with formal training in a psychoanalytic institute).

The frantic scramble of residents for admission to a psychoanalytic institute has various motivations. Since the teaching of psychodynamics is so well organized in the psychoanalytic institutes, residents hope, through this, to become better equipped in their understanding and treatment of patients. Many want to be qualified psychoanalysts because this promises maximum financial security. Since training in a psychoanalytic institute is considered the stamp of being a "first class" citizen, it is inevitable that none wants to be considered a "second class" one. It is not surprising therefore that this operates as an important motivation for securing psychoanalytic training.

We then formulated a questionnaire to secure further information. This was sent to the directors, teachers, and residents of every psychiatric residency training center

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geographically accessible to a psychoanalytic institute. We also sent a questionnaire to every psychoanalytic institute and to a proportion of their teaching analysts.

The questionnaires turned out to have many flaws; certain questions were confusing and unanswerable. However, some general trends emerged clearly.

Of 14 replies from directors of residency centers, all said that their training program included organized instruction in psychodynamics, although in 2 of these centers the residents felt that the program lacked it. There was found to be a wide variance as to what is considered psychodynamics. Also one must differentiate between a so-called psychodynamic orientation and organized instruction in psychodynamics.

Fifty-six percent of the psychiatric teaching staff in 14 training centers had had psychoanalytic training, and another 11% had had a personal analysis without formal psychoanalytic training.

We asked the teaching psychiatrists in residency centers to compare the performance of residents taking concurrent training in a psychoanalytic institute with that of those not in psychoanalytic training. Of 57 teaching psychiatrists, most said that they could not properly assess the effect of training at a psychoanalytic institute on the residents' performance because of so many variables, such as individual differences in residents as to native ability or amount and length of training experience. However, some teachers thought that it made for better performance. One teacher wrote, "Psychiatrists are more often born than made. If they've got it, they can improve it." Another teacher wrote,

> Some of the very best residents and some of the very worst residents I have ever had experience with have had either personal analysis or analytic training, and some of the very worst residents I have ever seen have not had any kind of analytic training.

Obviously, individual variations cannot be used as cogent arguments for or against psychoanalytic training concurrent with the psychiatric residency period.

Every teaching psychiatrist and teaching analyst indicated that organized instruction in psychodynamics should be part of the residency program. Two-thirds of the teaching psychiatrists in 11 metropolitan residency centers were either analytically trained or had had personal analyses.

After examining the curricula of psychoanalytic institutes we would raise the question of whether there should be any actual difference in the teaching of basic psychodynamics in a residency training center or in a psychoanalytic institute. When instruction in psychodynamics is given as something apart from residency training, problems due to the lack of integration are inevitable. For instance, one teacher wrote,

> I have been rather impressed by my observations that a number of young psychiatrists in training have been relatively poor in their clinical psychiatry because they are in such a hurry to compete with others in their knowledge and verbalization of analytic theory and formulation. Frequently they are very well versed in their knowledge of Fenichel, but amazingly ignorant of what is happening in the patient-doctor relationship in their work.

Might not such unfavorable situations be avoided through integration of psychiatric training?

Another teacher wrote, "If the teaching of psychodynamics is taken up too early, the student of psychiatry has no opportunity to learn psychopathology." This represents a common misconception of what constitutes psychodynamic theory. Psychodynamics, which is the theory of motivation, cannot exclude psychopathology since it begins with clinical symptomatology.

It is logical to expect that organized instruction in psychodynamic theory when given in a clinical setting and correlated with other medical disciplines such as physiology and biochemistry would, by utilizing a pluralistic approach, make for integrated training.

There was a difference of opinion as to how much instruction in psychodynamics might be considered desirable. In our questionnaire, we used as a point of reference the first-year courses in psychodynamics as given in the psychoanalytic institutes. Teaching analysts were asked if the equivalent of these courses could be given in residency training centers to (1) residents who are being analysed but who are not students in a psychoanalytic institute, and (2) residents who are neither being analysed nor are students in a psychoanalytic institute. Of 37 psychoanalysts, 22 stated that the equivalent of the

first-year courses in psychodynamics could be given to residents who are not students in a psychoanalytic institute, but who are being analysed. It is striking that 15 of these analysts were opposed to the teaching of psychodynamics to this extent in residency training centers for those residents with personal analysis. Even more striking is the fact that fewer analysts, only 10, were opposed to the teaching of psychodynamics to the same extent in residency centers to those residents who do not even have the supposed advantage of personal analysis.

It would appear that these confusions will persist so long as analysts teaching at psychoanalytic institutes and psychiatrists teaching at residency centers do not create the opportunity to work out these problems by pooling of their experiences.

Related to organized instruction in psychodynamics is the problem of personal analysis. If extensive training in psychodynamics is provided for all residents, should all have a personal analysis unless clinically contraindicated, whether or not there will be subsequent training in analytic techniques?

Of 165 residents in 11 residency training centers in New York, Philadelphia, Baltimore, Washington, and Chicago, 20% were in personal analysis on their own, *i.e.*, not enrolled as students in a psychoanalytic institute, and 26% were in psychoanalytic training. Thus 46% of these residents were having a personal analysis, and many of the remaining 54% are hoping to follow this plan. Of 57 teachers from 14 residency training centers, all but 5 considered a personal analysis either *useful* or *essential* for all residents, unless contraindicated clinically.

On the other hand, when teaching analysts were asked if analysis should be made available for all residents, unless contraindicated clinically, of 37 responses, 28 said "yes," 7 said "no," and 2 were equivocal. Since psychoanalysts believe that personal analysis, if properly conducted, brings about better adaptive behavior and greater use of individual resources, the position taken by these 9 analysts needs clarification.

We also asked, "If the goal of a resident's personal analysis was artificially limited to achieving for him reasonable freedom from problems arising out of counter-transference, could the analysis be modified in breadth, depth, or length of time?"

Of 37 teaching analysts, 25 answered "no" to the possibility of limiting it in any way, *i.e., depth, breadth, or time.* However, one teaching analyst wrote:

> Analysis could be sharply focused on the student's central emotional problems, which if accurately done could at least hit the main issues of his make-up. With each hour made to count, a lot that is very valuable may be accomplished in relatively short time, 50 to 100 hours.

The general consensus, however, was that there could be no modification of the personal analysis of students. If this is true, it raises some serious practical problems.

As to when it is advisable for a resident to have his personal analysis, whether or not it will be part of training in a psychoanalytic institute, 34 of the 57 teaching psychiatrists in 14 residency centers thought it should be early, *i.e.*, concurrent with or immediately after the first year of residency. These opinions come from those who teach and observe the residents in action and who should be in the best position to know how personal analysis early in psychiatric training affects a resident's performance. Of the analysts, half of them thought that analysis should begin with the residency, and only 7 thought it should be postponed until after 2 years of psychiatric residency.

When we asked residents who were having either personal analysis or analytic training if they felt that they had a broader outlook than their colleagues who had neither, almost all responded in the affirmative and thought that it improved their short-contact work with patients, also.

That personal analysis is essential for all doctors who are to become psychoanalysts has been assumed, but actually had not been investigated or studied. What are the changes it proposes to bring about? What are the changes it does bring about? Since many residents undergo personal analysis because they wish to become psychoanalysts, what are the results under such circumstances? These might be considered challenging questions, yet, although they have not been answered by any controlled experiment or study, almost all psychiatrists and psychoanalysts have a ready answer.

If residency training centers and psycho-

analytic institutes continue to go separate ways, this will perpetuate the dichotomy that originated in a fortuitous situation, namely, the historical exclusion of psychoanalysis from medical disciplines. The amount of pre-judgment and rigidity about maintaining such a separation, as indicated in the replies to our questionnaires, was striking.

At present, all but a few psychoanalytic institutes are so organized that the student, although he may begin his personal analysis early, as many now do, has more than 2 years of psychiatric training before he is allowed to take courses in psychodynamics at the psychoanalytic institute. Does this represent a recapitulation of the experience of those who make the rules? Should a beginning resident in psychiatry wait until he is in psychoanalytic training before he is made aware of the results of his own reactions even in history taking? Will teaching him Freud's "Three Contributions to the Theory of Sex" influence unfavorably the securing of factual data about a patient's psychosexual development? Will familiarity with mental mechanism reduce his capacity to observe and understand a depression or his skill to examine a catatonic? And if psychodynamics is taught in an organized way in the clinic and at the bedside as well as in the classroom, might not this be the greatest safeguard against misuse and abuse of theory?

Incidentally, one teacher wrote that "the questionnaire seems to consider organized training in psychodynamics as psychoanalysis." We point out again that psychodynamics draws on the data from psychoanalytic theory but is not restricted to it.

There are now in this country a few centers where psychiatric training is set up on an integrated basis, that is, without separation from psychoanalytic training. A unified plan would offer every resident the maximum training and experience he would be able to absorb emotionally and intellectually. Some would be encouraged to develop special skills, among them, for instance, investigative or therapeutic psychoanalytic skills, and for those there would be subsequent specific training toward this end. Others might be attracted to different aspects of clinical or research work. This, however, does not alter the concept of unified maximum basic training for all.

The psychoanalytic institutes have carried the burden of teaching the basic principles of psychodynamics. Since a dynamic psychology is now nuclear to psychiatry, the residency training centers must assume the task of teaching it. It is understood that this should not be continued beyond the point where it is useful to, and absorbable by, the resident. At present, although the specific boundaries are assumed, they have not been established. With an integrated psychiatric training, all knowledge pertinent to the theory and practice of psychiatry would be consolidated into a unified whole.

SUMMARY

1. In this study, all residents indicated a need for organized training in psychodynamics throughout their residencies.

2. Because of the many variables, observers could make no valid comparisons between the professional competence of residents who were in training at psychoanalytic institutes and those not being similarly trained.

3. Residents in training at analytic institutes felt that this did not set up restrictions or limitations nor interfere with their clinical work but, rather, operated in a positive way during the residency training.

4. All the teaching psychiatrists and all the teaching psychoanalysts agree that organized instruction in psychodynamics should be given in the residency training center.

5. Opinions about the value of a personal analysis independent of training for the practice of psychoanalysis were found to be based on tradition or personal experience rather than on investigative studies.

6. The general consensus of teaching analysts was that there could be no modification of personal analysis of residents as to depth, breadth, or time.

7. Half of the analysts who recommended that residents undertake a personal analysis stated that it should begin at the start of the psychiatric residency or before. There were only a few who felt personal analysis should not begin until after 2 years of psychiatry.

8. Some teaching analysts stated that psychiatric residents who had had or were having personal analysis on their own still should not have courses in psychodynamics that

would be the equivalent of that given in the first year at a psychoanalytic institute, although three-fifths of the teaching analysts felt that they should.

This preliminary study raises many questions

1. Since psychodynamics is nuclear to psychiatry, will not residency training centers have to include organized instruction in psychodynamics in their training programs?

2. Would it be advantageous to have didactic courses in psychodynamics taught in close relationship with, and applied through, "on-the-spot" supervision of residents in their day-to-day diagnostic, management, and treatment activities?

3. Should didactic courses in psychodynamics given in residency training centers differ from those given in psychoanalytic institutes as to *nature* or *extent* of content?

4. Should all residents get the same basic training?

5. If all residents in psychiatry get the same basic training might this provide a "proving ground" upon which effective selection could be made for subsequent specialized training in psychoanalytic therapy and, also, other special field of practice, research, or teaching?

6. Is the current separation between psychiatric and psychoanalytic training based upon actual differences in psychodynamic theory? If so, are these valid or are they artificially determined by a series of events originating with the historical exclusion of psychoanalysis from medical schools and perpetuated by the existence of separate psychoanalytic institutes?

7. Since the growing existence of organized courses in psychodynamics and the increasing number of psychiatric teachers with psychodynamic training indicates that some residency centers are beginning to take responsibility for some basic training in psychodynamics: (a) Can this instruction be better organized? (b) When should it be given? (c) What should be the professional training of those who give it?

8. Is a personal analysis essential to the optimum comprehension of psychiatric illness? (a) Has this been adequately tested and evaluated, or does it operate only through tradition and prejudgment? (b) What does it achieve?

9. For those residents who will be analysed, when should personal analysis begin?

10. Would integrated training encourage sounder testing of psychodynamic theory and practice?

11. By pooling qualified teaching personnel and creating an integrated training program, would this offer greater opportunities to the resident? Would it not also create maximum effectiveness for every psychiatric residency training center?

THE PSYCHIATRIST AS AN ADVISOR AND THERAPIST FOR MEDICAL STUDENTS[1]

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Many educators recognize that the maturation of the total personality is more important to a student in his life adjustment than the mere training of his intellect. During the past 30 years the mental hygienic aspects of education have been given increasing attention with the result that many colleges and universities now utilize the services of part- or full-time psychiatrists for purposes of counseling and psychotherapy. In most instances it has been found that these services are requested far in excess of the time that the psychiatrists have available. This situation does not necessarily imply that the student's need for psychiatric assistance is greater than before, but it does imply that psychiatry, when given the opportunity, can make a significant contribution to the educational process.

The development of emotional maturity is particularly significant in the educational preparation of the physician. Although the medical student is subjected to a great amount of environmental stress while preparing to assume professional responsibilities, physicians themselves have given little attention to the investigation of those factors that dynamically give rise to this stress. Some of these factors will be discussed as they are related to emotional and personality disorders found among medical students.

The Committee on Academic Education of the Group for the Advancement of Psychiatry(1) recently reported a review of the literature concerning the role of psychiatrists in colleges and universities. It is noteworthy that with one exception none of the 93 references cited deals specifically with the study of medicine. As a result of his clinical experience at Yale University, Fry(2) reported that vocational difficulties and indecision with regard to the choice of medicine as a career constituted two of the most significant problems that confronted him as a psychiatric consultant. He found that the real sources of failure lay less in the academic system than in the individuals themselves, that few cases presented problems of transition from one social and intellectual climate to another, and that economic insecurity was infrequently a factor of disturbance. He also found that medical students generally resisted psychotherapy and were often suspicious and skeptical of psychiatry. Strecker and his co-workers(3, 4) stated that the study of medicine was a strain on the physical as well as on the mental health of the student, and that no other professional preparation was more rigorous in its demands. After an analysis of a questionnaire submitted to senior medical students at the University of Pennsylvania, they concluded that a serious problem in mental hygiene exists in medical school, and that those individuals already neurotically handicapped face serious hazards in attempting a medical education.

It is one of the purposes of this paper to describe and evaluate a 14-year-old psychiatric service that has been devoted to medical students at Cornell University. Throughout this period psychiatrists, acting as advisors and therapists, have attempted to aid the students in their efforts to achieve the maturity required by the duties of a physician. Approximately 25% of the entire student body has requested psychiatric assistance at some time during the 4-year period of training. This figure very likely is consistent with the findings of other medical schools where similar consultation services are provided. The frequency of such requests does not necessarily indicate an unusually high incidence of psychiatric disorders, since many of the students seek advice for problems that are common to the general population. Any group of individuals under similar environmental stress and with the same degree of insight into the nature of their personal problems would probably learn to accept and apply

[1] Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

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psychiatric principles to a dynamic evaluation of their own personalities.

Since the availability of the psychiatrist is made known primarily through teaching, the greatest number of requests for aid are self-initiated and directed toward the instructors. Some patients are referred by the Dean's office, the Student Health Department, and by other students who have consulted the psychiatrist in the past.

To best meet the needs of his patients the psychiatrist must be adequately trained and experienced in psychotherapy. Not only must he assume responsibility for all those students who are emotionally ill, but he must also be prepared to follow the course of former patients as well as those who are under the care of other members of his staff. As a member of the faculty he should maintain close contact with other physicians in authority and, when necessary, attempt to gain their understanding and cooperation in therapeutic management. It is desirable for the psychiatrist to have a thorough knowledge of the school's curriculum, which determines to some degree the student's emotional reactions and disorders. Attendance at faculty meetings enables the psychiatrist to follow the academic progress of each student as well as gain information with regard to his interpersonal relationships. Active participation in the daily routine of the school has been found to enhance the acceptance and availability of the psychiatrist as a therapist. Therefore, a consultant not directly associated with the school and unknown to the students might be seriously handicapped in obtaining self-initiated requests for psychiatric aid. A therapist who also acts in an administrative capacity within the school might be handicapped since the patient might regard his academic status as threatened by such authority and consequently display greater resistance to psychotherapy.

Owing to the confidential nature of psychiatric treatment the student patient is assured that both the nature of his illness and personal information will not be revealed to other members of the faculty. He is also informed that case records are filed in the psychiatrist's office and thus apart from the case records of the Student Health Department. When a student is seriously ill and refuses to accept treatment he is informed that administrative authorities of the school will assume the responsibility for his final disposition. In situations where academic problems exist, the Dean or one of his representatives may be consulted, but only with the student's consent. Without exception all members of the faculty have accepted this system and have given every consideration to the role of emotional factors in the student's intellectual performance.

The dual role of the psychiatrist as a teacher and therapist has not been found to constitute a serious handicap to the successful management of student patients, except when treatment is necessarily intensive and prolonged. The student may have difficulty in accepting his teacher as a therapist particularly when teaching is confined to small groups. In such cases transfer to another group is made whenever possible. The teaching of psychiatry may mobilize anxiety particularly in those individuals who are already insecure or emotionally unstable. Therefore, the teacher is in a position to observe and deal with early signs of psychopathology as well as counteract anxiety by the introduction of concepts of mental hygiene. Since lectures and clinical presentations often are interpreted subjectively by the students, anxiety may be revealed by the nature of their questions and comments. The invitation to discuss them privately frequently leads to an initial introduction to psychotherapy with a minimum of embarrassment and resistance. In most instances such students have expressed the desire or willingness for further investigation of their personality problems. A positive student-teacher relationship can be utilized significantly in establishing an optimal case-finding technique. The teacher who displays interest in the student's individual problems and succeeds in establishing an attitude of tolerance and understanding often will stimulate the students to seek his aid. The result of such a relationship has been strikingly demonstrated by the fact that 42% of a recent freshman class of 80 has voluntarily requested assistance from the teacher, who is also available to them as an advisor and therapist. It is probable that an even greater number of students from this

group will consult the psychiatrist before completion of their professional training.

Of the total number (123) of students who consulted the writer during the past 3 years, 60 (48.8%) were seen from 1 to 3 hours in an advisory capacity or for treatment of minor personality disorders. Information was frequently requested with regard to the problems or illnesses of friends and relatives. In some cases arrangements were made to interview and advise the individuals in question. Difficulties in interpersonal relationships with other students who were room-mates or laboratory partners were likewise frequent but minor complaints. With the recognition of the role of personality factors in the choice of medicine as a career and in the choice of a medical specialty, a number of requests for reassurance were brought concerning the likelihood of fulfilling professional ambitions. Other students looked to the psychiatrist for help in improving methods of study. Anxiety derived from minor sexual conflicts was usually relieved within a short time through catharsis and reassurance. The disorders found among this group of students were, for the most part, transient problems of personality growth and development.

Sixty-three (51.2%) of the students who consulted the writer were found to have marked emotional or personality disorders and were treated over periods of 5 to 50 hours. The nature and number of these disorders occurred as follows:

Psychoneuroses	34
Mild transient paranoid states	8
Panic reactions	7
Character neuroses	7
Depressions	5
Schizophrenic reactions	2

Six patients within this group withdrew from school while 2 proceeded to graduation after repeating the academic year. Two who required prolonged treatment within a psychiatric hospital (Payne Whitney Clinic) returned to school upon recovery. One succeeded in terminating his life while under treatment. Another, who had concealed his illness from the psychiatrist as well as from his classmates and other members of the faculty, also made a successful suicidal attempt. Suicide, more than any other factor, focused the school's attention on the importance of the role played by the psychiatrist in the student health program.

The nature of the student's complaints was to some extent directly related to the source of referral. Those who were referred by the Dean's office presented problems that were generally academic and vocational in nature. Failures and poor work records most often were related to emotional instability, rather than to lack of interest or intellectual inadequacy. Psychological testing verified these findings to a considerable extent. Students who were referred by the Student Health Department commonly reflected their anxiety in physical symptoms and demonstrated the most marked resistance to psychiatric investigation and treatment. The nature of the complaints also varied with the year in which the students matriculated. The quantitative nature of the work with its limitations of recreational and social activities was found to constitute the major problem of adjustment during the first year. Hypochondriasis, which was a rare complaint at first, became evident in the second year when courses of study such as pathology and physical diagnosis were introduced into the curriculum. This manifestation of anxiety occurred more or less throughout the next 2 years. Problems arising in the patient-physician relationship and difficulties in the application of basic sciences to clinical medicine were the complaints most commonly encountered in the third and fourth years.

Among the psychoneurotic reactions encountered by the writer, anxiety states were most common and were generally related to fear of failure, the threat of competition, dependency needs, sexual conflicts, and hypochondriasis. Manifestations of a neurotic personality adjustment were most frequently found in the student's interpersonal relationships. Sexual problems included frigidity, impotence, masturbation, and overt homosexuality. Those states that have been classified as paranoid were characterized by mild projections and sensitive ideas of reference, and were related, for the most part, to body overconcern and unacceptable homosexual strivings. Panic reactions were precipitated both by fear of failure in work, and by sexual conflicts. Students showing character

neuroses consulted the psychiatrist because of personal difficulties due to alcoholism, feelings of hostility, and sexual promiscuity. Depressions were usually reactive to rejection by a loved object, failure in marital adjustment, and poor academic performance. The 2 students who presented schizophrenic features were borderline cases and both demonstrated conflict between religious and medical standards.

Owing to the fact that the majority of these patients readily accepted treatment, were of superior intelligence, and were well organized and generally possessed some insight into the nature of their disorders, good therapeutic results were common. When personality disorders were both deep-seated and resistant to psychotherapy, symptomatic relief was necessarily the therapeutic goal because of the limitation of time. In such cases the students were advised to undertake more intensive therapy at a later date when they would be better able to afford the time and expense.

During the course of interviews, the students described a number of environmental factors that they regarded as dynamically significant in their adjustment to medical school. Although the majority of students possess superior intellect, the academic demands of the curriculum constitute a major problem of adjustment. Factors other than lack of interest and emotional instability may seriously interfere with successful utilization of superior intellect. Thus, the transition from passive to active learning requires that the student rely less upon directive assignments, independently organize a large amount of new material, and select for himself what is essential to his own intellectual development. Even when a high academic status was achieved in undergraduate school with relative ease, and in spite of faulty study habits, the student must seek new methods of study in order to maintain a high degree of efficiency. The detailed, factual nature of the basic sciences calls for superior memory, and at the same time tends to block imagination and creativity formerly realized during the process of undergraduate education. Limited time blocks the pursuit of those topics of particular interest. Owing to the pressure of the day-to-day curriculum, even minor physical illnesses may constitute a threat to the student's security, since there is little or no time for make-up work.

The destructive nature of intense competition among medical students has long been recognized and definite progress has been made in alleviating this situation. However, competition nonetheless continues to exist and constitutes a frequent source of emotional distress. In undergraduate school each student is aware of the fact that many applications to medical schools are rejected on the basis of inadequate academic performance. Such a situation fosters competitive attitudes. Upon entry to medical school he further finds that the intellectual qualifications of his classmates are equivalent to his own, and that he, like others, may have to accept an inferior academic position in his class. Although students are informed that superior academic achievement will not assure their success as physicians, it still determines to a large extent the quality of internships and residencies that are obtained after graduation.

The fear or intolerance of failure is evident in almost every student. Not only does he realize that he was chosen for admission to medical school on a competitive basis, but also that much is expected of him by those relatives and friends who have supported him in his choice of a career. Furthermore, failure implies that he would have to relinquish his medical ambitions since the chances of re-admission to another school after failure are slight if not impossible.

Ambivalence with regard to the choice of medicine as a career is not infrequent during the first year. In the student's efforts to establish independent life goals, conflicts may arise between his own desires and external pressures. Academic progress then becomes increasingly dependent upon the conviction that he is striving toward a goal attributable to his own volition. He can no longer hold others responsible for the discomfort he experiences in his work. When such discomfort becomes intolerable he may feel trapped or react with extreme resentment toward those upon whom he is dependent.

The transition from undergraduate to graduate school is accompanied by numerous dynamic changes in the student's social environment. He no longer occupies the socially

secure position of a senior, but must once again adjust himself to the lesser social status of a freshman. During the first 2 years of medical school, little praise or acknowledgement is given to personality assets other than intellectual achievement. This is in distinct contrast to the time when success in extracurricular activities and leadership were outstanding criteria of recognition in the total evaluation of one's personality. Thus many assets, which to some extent determined his admission to medical school, are overlooked and consequently are less a source of security. Since limited time, owing to academic demands, necessitates a voluntary curtailment of social and recreational activities, the substitution of reality for pleasure principles may constitute a serious problem in the student's personality development. He must learn to organize his own extracurricular activities and can no longer rely upon the school for social guidance. When students do enter into social activities, they frequently experience feelings of guilt since graduate work is unlimited in its scope and rarely can be regarded as complete. Limited time also results in the loss of contact with old friends and markedly interferes with the pursuit of romantic interests. Thus social competition with other men of the same age group may constitute a serious problem. Since all his classmates have similar interests and ambitions, the medical student may experience lack of intellectual stimulation formerly enjoyed in the exchange of ideas with students of other interests and life goals.

The prolonged state of dependency required in most instances by a medical education often complicates personality maturation in the student's transition from adolescence to adult status. Financial dependency may seriously interfere with his efforts to emancipate himself emotionally from his parents. Resentment is consequently a frequent reaction and may be expressed as anxiety when the student is also aware that his parents have made extreme financial sacrifices in order to support him in his career. He may develop a similar attitude toward scholarship support since he then feels obligated to maintain high academic standards in order to justify his financial dependence. Debts incurred during the school years may block his desire to pursue a long course of special training after graduation. Thus he may feel frustrated in the attempts to achieve professional perfectionism as it is taught by his teachers.

A prolonged state of dependency also complicates the student's adjustment to problems of sex and marriage. Since marriage is often necessarily postponed, sexual problems are a frequent occurrence. The unmarried student is financially limited in courtship and has little time to establish a secure love relationship. In some instances an increasing awareness of social demands of the medical profession may give rise to the development of higher moral and ethical standards with consequent frustrations. Autoerotic activities may be continued for a longer period than is desired by the student himself and consequently may result in an exaggerated sense of guilt. Limited contact with members of the opposite sex may activate latent homosexual strivings, while compensatory sexual fantasies may increase tensions and anxiety and thus interfere with concentration.

In recent years marriage among medical students has become more common, owing to cultural changes and to financial support available to veterans. Hospital appointments are now less influenced by the student's marital status than before. Wives who work have become more socially acceptable and thus can contribute to the support of their student husbands. However, financial dependency upon wives often gives rise to resentment and guilt, and thus may create marital difficulties. Financial limitations may necessitate postponement of reproduction, which likewise may interfere with the achievement of a successful marital adjustment. Some students who have children find difficulty in dividing available time between work and family. Others find that marriage benefits their capacity for work since they feel more secure, are confronted with less social temptation, and are more sexually satisfied.

In cases where a conflict between religion and science reflects marked immaturity, the student is generally able to reconcile his conflicting beliefs during the ensuing process of personality growth. When present, resentment is usually directed toward specific members of the faculty who utilize authority as a defensive measure against their own per-

sonal insecurity. In general, feelings of resentment are easily managed since the students readily recognize the nature of these defenses. Such medical practices as dissection of cadavers, vivisection, and examination of excrements do on occasion meet with repulsion but rarely constitute a major problem of adjustment.

The student's adjustment to medical school is also dependent upon his ability to foresee the fulfillment of his needs and ambitions through professional training. When this is possible he is better able to tolerate the stresses of his work and to postpone pleasure for future gain. As a physician he will have the opportunity to continue his intellectual interest in science and to gain a better understanding of himself and others. He will be reasonably certain of social and economic security, be independent in his work, and offer an indispensible service to his community.

SUMMARY

During the past 14 years approximately 25% of the entire student body at Cornell University Medical College has requested the assistance of a psychiatrist as an advisor or therapist. Any other group of individuals under similar stress at the same life period, and with the same degree of psychiatric insight, would probably respond in a like manner. The greatest number of requests for psychiatric aid were self-initiated and were directed toward the instructors. When anxiety was mobilized by the teaching of psychiatry, the instructors were able to recognize early signs of psychopathology, and to deal with them either by introducing concepts of mental hygiene into lectures or by inviting personal interviews. The dual role of the psychiatrist as a teacher and therapist was generally found to be more of an asset than a handicap in the development of an optimal case-finding technique, and in the successful therapeutic management of student patients. There was relatively little resistance to psychiatric treatment and in most instances the students were eager to pursue a more thorough investigation of their complaints and problems than time permitted.

Of the total number (123) of students who consulted the writer, 48.8% were seen from 1 to 3 hours in an advisory capacity or for treatment of minor personality disorders; 51.2% were found to have marked emotional or personality disorders and were treated for periods of 5 to 50 hours. The complaints or disorders themselves were related to some extent to the source of referral and to the year in which the students matriculated. Those environmental factors regarded by the students as most dynamically significant in their adjustment to medical school were the extreme academic demands, the threat of failure, competition, the transition from undergraduate to graduate school, economic insecurity and dependency, and obstacles to sexual satisfaction and marriage.

BIBLIOGRAPHY

1. The Role of Psychiatrists in Colleges and Universities. Formulated by the Committee on Academic Education of the Group for the Advancement of Psychiatry. Report No. 17, 1950.

2. Fry, Clements C. Mental Health in College. The Commonwealth Fund, New York, 1942.

3. Strecker, Edward A., et al. Psychiatric studies in medical education. Am. J. Psychiat., **92**: 937, 1936.

4. Strecker, Edward A., et al. Psychiatric studies in medical education. II. Neurotic trends in senior medical students. Am. J. Psychiat., **93**: 1197, 1937.

INTENSIVE ELECTROSHOCK TREATMENT WITH REITER APPARATUS[1]

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Ever since the introduction of electroshock therapy attempts have been made to achieve the most effective results within the shortest time. The proper spacing of treatment with electroshock has been considered by most therapists to be about two or three times a week. This was arrived at because more frequent administration led at times to rather severe organic confusion. However, this latter state was thought desirable by some observers. Bini(1) in 1942 suggested the repetition of electric shock treatments many times a day for certain patients. He named this technique the "Annihilation Method." It resulted in very severe amnestic reactions that he thought had a good influence on obsessive states, psychogenic depressions, and some paranoid conditions. The patient would be shocked daily for 3 or 4 days followed by a 3-day rest. Lowenbach(2) also administered intensive shock therapy with the express purpose of inducing confused states. He called his treatment the "Confusional Treatment." The explicit purpose was to create a period of confusion lasting for many days. Twelve treatments would be given daily and the confusion would usually become manifest after the eighth treatment. Many other authors have utilized this technique for various conditions(3-11). The number of treatments varied from once a day to as many as 13 a day, in certain cases(8).

Some authors(7, 12) have not seen any advantage, in most instances, in giving such intensive treatment. Others(13) have regarded the severe degree of amnesia as possibly an undesirable accompaniment. At times too frequent treatments may result in severe organic confusional states with engrafted transitory psychotic reactions(14). These complications led some therapists to question the frequent administration of treatment, although occasional exceptions were made.

With the introduction of the unidirectional current some of the organic complications resulting from administration of excessive current were considerably reduced. This goal was especially accomplished with the use of the Reiter Electro-Stimulator. This instrument has now been in use over 10 years and was first reported on by Friedman and Wilcox. It employs a unidirectional current consisting of approximately 30 groups of pulses per second. Within each group are roughly 6 steep-walled pulses each topped by a spike. These 6 pulses are of varying amplitudes and relative phase arrangements within each group. The average current used per treatment as read by the meter ranges from 3 to 20 milliamps, and the average voltage used runs from 1½ volts to 10 volts; thus the usual average treatment requires an average current of about 7 milliamps and an average of 3½ volts. The peak currents represented by the single duration spikes may go as high as 400 milliamps at infrequent times during one treatment. The current is applied for the entire duration of the convulsion, about 45-60 seconds instead of a fraction of a second.

The marked reduction in the organic changes with this apparatus led us to the thought that possibly frequent administration with it might produce effective results in a relatively shorter time without the organic confusion caused by the standard electroshock machine. Wilcox(15) in a review of over 23,000 treatments using unidirectional current pointed out that the treatment could be given as frequently as indicated by the patient's condition. Most patients were started on a daily treatment program and

[1] Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

From the Department of Psychiatry, New York University, College of Medicine, and Bellevue Hospital.

the frequency was decreased as the patient showed signs of responsiveness.

We began to treat patients with the Reiter Electro-Stimulator and eventually evolved a technique in which treatment was given in an intensive and concentrated fashion. In the main the following routine was observed. The patient was generally given 2 electric shock treatments the first day, and one a day thereafter. If the patient was quite agitated he was given two a day until the agitation subsided somewhat, and then continued with one a day. After the patient began to improve the frequency was cut down and rest days were interposed. Other patients were started with one-a-day treatments for 3 to 4 days and then rest days were interposed.

We are reporting in this paper a series of depressions treated in an intensive fashion with the Reiter Electro-Stimulator. These depressions were of the manic-depressive and of the involutional type, totaling 34 cases. Four of these we shall discuss separately for reasons that will be indicated below. The other 30 form the main body of our case material. We shall concern ourselves mainly with 2 aspects of the problem: first, the number of treatments, and second, the number of days necessary to complete treatment. The 30 cases that form the body of the material all got well, and follow-up study revealed them to be adjusting in the community from 2 to 10 months after treatment.

In these 30 cases it will be noted (from Table 1) that the number of days to complete treatment ranged from 2 to 12, and the number of treatments from 3 to 8. In 23 of the 30 cases treatment was completed in 7 days or less; in other words, the majority of cases were treated successfully within a week with the number of treatments ranging anywhere from 3 to 8. Most of the treatments were given in the first few days. There is no question that this compares quite favorably with the results achieved with the usual A.C. machine and the period of time required to complete the treatment is considerably less. In our series the number of treatments in the lower range, namely 3, would have required a week or more with the old technique instead of 2 days with ours, while in the upper range those who needed 8 treatments would have required at least 3 weeks, or more, instead of 1 week. Thus it is seen that considerable sickness time is saved by our technique. It is rather difficult to find comparable cases for control purposes, but a rough survey of 35 depressions treated on our service with the classical machine reveals the amount of time for completion of treatment to be 2 to 4 weeks instead of 2 weeks or less as in the present study.

There were 4 cases that deserve special mention. One case required 6 treatments in 17 days. This patient was given 2 the first day, then a rest day, then another treatment following which he improved. After about 11 days he relapsed somewhat and received 2 more treatments and then remained well. It can be seen that the 11-days lapse is responsible for the long duration of treatment. The same was true of another case who received 11 treatments in 21 days. Here again the patient received about 8 treatments and then there was a 10-day nontreatment period following which the patient relapsed somewhat and then had to be given 3 more treatments in order to reach a point of satisfactory improvement.

In two cases we ran into a rather interesting reaction that has been reported previously by some of us, namely, a superimposed psychotic reaction, which seemed to occur after treatment had been discontinued. This psychotic reaction lasted 2 to 3 weeks and then subsided. In both instances the patient was sufficiently improved to warrant no further treatment. In one instance the patient had 5 treatments in 4 days and improved sufficiently for discontinuation of treatment. On the ninth day following this the patient became psychotic and had delusional material

TABLE 1

34 PATIENTS TREATED WITH UNIDIRECTIONAL CURRENT

Number of days..	2	2	2	3	3	3	4	4	4	4	4	4	5	5	5	5	5
Number of treatments	3	3	3	4	4	4	3	4	4	4	4	5	4	4	4	4	5

Number of days..	5	5	5	6	7	7	8	9	9	9	10	10	12	17	21	45	43
Number of treatments	6	6	6	8	5	5	7	6	7	7	7	8	8	6	11	11	17

unlike that which she expressed in the course of the original psychosis that led to her admission. She was perplexed, bewildered, had feelings of unreality, but was oriented in all spheres. She finally recovered and was able to return home. A similar picture was shown by another patient.

It is difficult for us to evaluate why both of these patients had this reaction since certainly as far as we could tell they did not receive any more intensive treatment than some of our other patients who did not develop these reactions. Disregarding these few patients it would certainly appear that the 30 remaining did well in less than 12 days.

Discussion

For purposes of this presentation we concentrated only on depressions, since we know that the classical form of electroshock therapy produces its best results with this type of illness. We could therefore have a fairly good frame of reference to evaluate our own material. Naturally we achieved our best results with the depressions. We did treat a number of schizophrenics and found that our worst results were with them. We are not in a position at this time to evaluate the schizophrenic treatment too clearly, since for the purposes of this project we were not interested in the number of treatments that would get the patient well ultimately, but whether the patient would get well quickly in a somewhat shorter time than that required with the classsical technique.

There are many other aspects that we could discuss in more detail; for instance, whether there was any correlation between number of treatments and duration of illness. However, we would like to point out that we took our case material in a rather unselected manner, namely, any patient who had a depression of either the manic-depressive or the involutional type in which we were fairly sure that the depressive picture was in the foreground. In our 34 cases, all of whom got well, we were not impressed by any great correlation between the duration of illness and the number of treatments required for the patient to get better; for instance, one patient who had been ill for 7 months required 6 treatments in 5 days; another who had been ill only a few weeks required 3 treatments in 2 days; and still another who had been ill for 3 or 4 months required 4 treatments in 3 days; one who had been ill for 8 months required 6 treatments in 5 days; so that in the main we could not say that there was any direct correlation, certainly insofar as the depressions were concerned, between the duration of illness and the amount of treatment required.

SUMMARY

A series of 34 depressions was treated with the Reiter Electro-Stimulator, which is a machine giving a unidirectional current. In view of the rather noticeable absence of confusion with this apparatus, it was decided to treat these patients intensively. Treatment was therefore administered in a relatively short period, so that 30 of the 34 cases were completed successfully within 12 days and 23 of the 34 in a week or less. All the patients got well and have remained well for months afterwards. The number of treatments ranged, in 30 of the 34 cases, from 3 to 8, given within 2 to 12 days. Four of the 34 presented special problems, and 2 of these 4 showed a rather interesting psychotic reaction that could not be entirely explained by the form of treatment administered.

Comparison with the classical technique, which is given 2 or 3 times a week, showed that favorable results were achieved with our technique in a shorter time without any undue complications. The general form of treatment followed was to give the patient 2 treatments the first day and one thereafter for the next 2 or 3 days, by which time the patients usually improved, and then there was a tapering off, when rest days would be interposed. Sometimes if the improvement manifested itself right away the rest days were interposed earlier.

It is our impression, because of the appreciable shortening of the time required for treatment and the relative absence of complications, that this form of treatment is indicated in depressions.

BIBLIOGRAPHY

1. Cerletti, U. Old and new information about electroshock. Am. J. Psychiat., **107**: 87, Aug. 1950.

2. Lowenbach, H. Electric shock treatment of mental disorders. North Carolina M.J., **4**: 123, April 1943.

3. Geoghegan, J. J. The "shock therapies" at the Ontario Hospital, London. Canad. M.A.J., **56**: 15, Jan. 1947.

4. Kennedy, C. J. C., and Anchel, D. Regressive electric-shock in schizophrenics refractory to other shock therapies. Psychiatric Quart., **22**: 317, 1948.

5. Kerman, E. F. Electroshock therapy with special reference to relapses and an effort to prevent them. J. Nerv. & Ment. Dis., **102**: 231, Sept. 1945.

6. Valentine, M. Intensive electroplexy. J. Nerv. & Ment. Dis., **109**: 95, Feb. 1949.

7. Kalinowsky, L. B. Present status of electric shock therapy. Bull. New York Acad. Med., **25**: 541, Sept. 1949.

8. Singh, K. Intensive electrical convulsive therapy in a military hospital. Indian Med. Gazette, **85**: 41, Feb. 1950.

9. Milligan, W. L. Psychoneuroses treated with electrical convulsions. Lancet, **251**: 516, Oct. 12, 1946.

10. Fitzgerald, O. W. S. Experiences in the treatment of depressive states by electrically induced convulsions. J. Ment. Sci., **89**: 73, Jan. 1943.

11. Page, L. A. M., and Russell, R. J. Intensified electrical convulsion therapy in the treatment of mental disorders. Lancet, **254**: 597, April 17, 1948.

12. Kalinowsky, L. B. Electric convulsive therapy, with emphasis on importance of adequate treatment. Arch. Neurol. & Psychiat., **50**: 652, Dec. 1943.

13. Funkhouser, J. B. The symptomatic use of electric convulsive therapy for acute psychoses of military personnel. Psychiat. Quart., **22**: 204, April 1948.

14. Frosch, J., et al. Some reactions seen after electric shock treatment. Am. J. Psychiat., **102**: 311, Nov. 1945.

15. Wilcox, P. H. Electroshock therapy: A review of over twenty-three thousand treatments using unidirectional currents. Am. J. Psychiat., **104**: 100, Aug. 1947.

16. Martin, M. G. A practical treatment program for a mental hospital "back" ward. Am. J. Psychiat., **106**: 758, April 1950.

17. Stengel, E. Intensive E C T. J. Ment. Sci., **97**: 139, Jan. 1951.

DISCUSSION

DR. LOTHAR B. KALINOWSKY (New York City).—The authors' presentation illustrates first of all the high recovery rate in depressions and, second, the small number of treatments with which it can be achieved. This is in full accordance with my own experience that, contrary to schizophrenia where large numbers of treatments are necessary even in patients with early improvement, it is quite unnecessary to give a great number of treatments in depressions.

The interesting point of the paper is that in the majority of cases this small number of treatments can be given within less than a week, even in ambulatory treatment if the usual treatment confusion does not interfere with such procedure. The authors achieved this with the unidirectional current of the Reiter machine. My personal experience with previous modifications of ECT has not convinced me that the claim made by the manufacturers was justified. I could not find these modifications superior to the standard technique, and so after fair trials I gave up first electronarcosis and later the brief stimuli technique. More important than my own experience is the fact that actually none of the various modifications of the last 10 years really replaced the Cerletti-Bini method, and we all know that if something is really superior, it is soon taken over by all clinicians even against heavy opposition. A good example is ECT itself, which in spite of all objections became a routine procedure in practically all mental hospitals throughout the world.

I would like to know if the authors used the newer Reiter machine, which is a combination of unidirectional and brief stimuli technique. Such current is now being used by us at the Psychiatric Institute, so far without convincing results. All the more interesting is it to me that this favorable report comes from authors with such large experience with the standard technique of ECT. A strange and noteworthy point is the occurrence of two acute organic reactions in a material of 28 cases, which amounts to over 7%, while in my experience with the standard method I do not think that I saw these reactions more often than in a fraction of 1%; this although I am watching out for them carefully because of my special interest in this subject.

In their own first report on these organic reactions the authors, too, had seen them only twice in an obviously much larger material than these 28 cases. I do not want to draw a definite conclusion that they are more frequent because of the current used, but if these reactions were organic reactions they prove that the Reiter technique does not prevent the temporary brain damage that underlies all types of organic side-effects of ECT. I still feel that neither the amount of current applied nor the type of current is responsible for any of the effects of ECT but that the convulsion is responsible for both therapeutic effect and undesirable side-effects. Yet, we must investigate all new methods in the hope to reduce the undesirable side-effects and, therefore, such material as presented by the authors is extremely interesting and stimulating.

PROCEEDINGS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

THE ONE HUNDRED AND SEVENTH ANNUAL MEETING
CINCINNATI, 1951

The One Hundred and Seventh Annual Meeting of the American Psychiatric Association was held at the Netherland Plaza, Gibson, and Sinton Hotels in Cincinnati, Ohio, May 7 through 11, 1951. The first general session was called to order at 9:30 A. M., May 7th by the President, Dr. John C. Whitehorn. The Right Reverend R. Marcellus Wagner gave the Invocation, and Mayor Albert D. Cash welcomed the Association to Cincinnati. Dr. Whitehorn responded appropriately to this gracious welcome and then introduced to the membership the President-Elect and several visitors and members from foreign countries. After Benediction by Rabbi James G. Heller, the business session began.

The report of the Medical Director, Dr. Daniel Blain, was given and received with interest and appreciation. The Chairman of the Committee on Arrangements, Dr. Thomas A. Ratliff, made a few announcements and reported a registration of over 3,500. Dr. David A. Young, Chairman, of the Program Committee, reported on the Committee's work in planning the program, and asked the members for comments or suggestions for the Committee's use in future program planning.

The Secretary, Dr. R. Finley Gayle, Jr., announced that the total membership was now 5,856, including 1272 Fellows, 3,584 Members, 665 Associate Members, 237 Life Fellows, 19 Life Members, 46 Corresponding Members, and 10 Inactive Members.

The next matter of business was the report of the Treasurer, Dr. Howard W. Potter, for the period April 1, 1950, to March 31, 1951. This appears separately as a part of these Proceedings.

The President-Elect Dr. Leo H. Bartemeier, took the chair and the President, Dr. John C. Whitehorn, gave a most interesting and stimulating Presidential Address on "The Individual Psychiatrist and Social Psychiatry."

A memorial to Dr. William Logie Russell, Past President of the Association, was read by Dr. Frederick Parsons.[1] The Convention rose in honor of this distinguished gentleman, and remained standing while the Secretary read the roll of all members deceased during the past year.

At the general session for members on May 8, the report of the Committee on Committees, covering approximately two years of work, was presented by the Chairman, Dr. Robert Felix. He stated that his Committee had found great confusion in the committee setup, and after much study had made the following recommendations for committee organization, which Council had adopted:

1. The purpose of each committee was defined, and rules for their operation set up.
2. Standards for committee reports to Council were developed.
3. A policy adopted that committees should hold meetings during the Annual Meeting and plan programs for the coming year.
4. All committees, depending on their function, were grouped under one of three coordinating committees: Committee on Technical Aspects of Psychiatry, Committee on Professional Aspects of Psychiatry, and Committee on Community Aspects of Psychiatry. The coordinating committees are made up of the chairmen of the committees in the group and are presided over by a member of Council. Their duties are to integrate the planning and activities of the grouped committees, and to present to Council a coordinated report of activities and recommendations.

The Chairman of the Board of Tellers, Dr. Crawford N. Baganz, gave the result of the mail ballot for the election of officers and Council members, and reported the election of the following: President-Elect, Dr. D. Ewen Cameron; Secretary, Dr. R. Finley Gayle, Jr.; Treasurer, Dr. Howard W. Pot-

[1] This Memorial appeared in the July 1951 issue of the JOURNAL.

ter; and members of Council, Dr. J. Fremont Bateman, Dr. William B. Terhune, and Dr. Frank J. Curran.

Dr. Whitehorn reported upon and gave a brief outline of the new APA Manual of Organization and Policy, which Council recommends to the membership for adoption. He stated that the general purpose of the Manual is to make clear to all new members, committee chairmen, officers, and other interested persons the organization and function of the Association. It will contain, among other things, a Code of Ethics (made up of the combined Codes of the American Medical Association and the Canadian Medical Association), the Constitution, Certificate of Incorporation, committee organization, etc.

The general session on May 9 opened with the reading of a telegram of congratulations and appreciation from Vice Admiral Joel T. Boone, Medical Head of the Veterans Administration.

There followed a report by the Secretary, Dr. R. Finley Gayle, Jr., of the principal activities and important actions of Council at its meetings on November 6, 1950, March 10, 1951, and May 5, 1951. The report of Council was duly voted as accepted by the membership. The President recorded the vote as that of two-thirds of the members present since such a proportion of the votes is required for the acceptance of a District Society, and the report contained Council's recommendation of the acceptance of such society. Reports of Council and Executive Committee meetings appear separately as a part of these Proceedings. The recommendation of Council and the Committee on Membership relative to the election of new members and changes in status of certain members was given and unanimously accepted.

A condensed Auditor's report was presented by Dr. Coyt Ham in the absence of Dr. Thomas W. Hagerty, Chairman of the Auditor's Committee. This report showed that the financial affairs of the Association are in excellent shape.

At the annual banquet on May 9 the Mental Hospital Achievement Awards were presented, and the Hofheimer prize[2] was awarded to Dr. Juergen Ruesch, whose acceptance speech follows.

Mr. President, Dr. Lewis, Ladies and Gentlemen:

On behalf of my colleagues of The Langley Porter Clinic who cooperated with me in this study, I accept with great pleasure and gratitude the Hofheimer Award for Research in Psychiatry. Now, at a time when the practical aspects of psychiatry tend to overshadow the interest in scientific inquiry, the generous recognition given to our interdisciplinary research team is a heartening encouragement.

Psychiatry is both an art and a science. As medical specialists we use personally acquired skills to cope with the preventive and therapeutic aspects of mental diseases; as scientists we gather information, we ascertain facts, and we communicate these facts to colleagues and students in order to build up gradually a psychiatric body of knowledge. Sometimes it is difficult to maintain a proper balance between psychiatry as an art and psychiatry as a science; thus the majority of talented young psychiatrists prefer practice to the less rewarding and sometimes tedious research work. As a matter of fact, the situation is so bad that today it is hardly possible to find medical men who are willing and desirous to undertake investigative work in the field of mental disease.

The vacancy left by the psychiatrists meanwhile has been occupied by psychologists, anthropologists, sociologists, biochemists, and neurophysiologists. While these scientists carry on fruitful research in normal and abnormal behavior and even go so far as to formulate principles of therapy, we, as physicians, are content to lean on the knowledge that the great psychiatrists of the past have left us as inheritance. This drought in creative thinking for the moment is still hidden by a boom in psychiatric education. But when the bullish sentiment will turn bearish, the scarcity of scientific information in our field will become evident.

The dilemma can be solved in several ways. The solution that we have chosen is to cooperate with the allied fields by establishing an interdisciplinary research group. The psychiatric members of the team point out the problems relevant to mental disease and keep the individuality of the patients in mind, while the social and natural scientists apply their modern methods that bear upon statistical mass effects. I shall take the Hofheimer Award back to San Francisco as a sign that this viewpoint has been honored. Thank you.

At the general session on May 11, the report of the Committee on Resolutions was presented by the Chairman, Dr. Benjamin Balser, as follows:

Your committee places before you the following resolutions:

1. *Resolved,* That the President and members of The American Psychiatric Association, convened in Cincinnati for their 107th annual meeting, do hereby express their appreciation to His Honor, Albert D. Cash, Mayor of Cincinnati, for the cordial welcome he has extended our members.

[2] Refer to the July 1951 issue of the JOURNAL, p. 62.

2. *Resolved*, That special thanks be voted to the University of Cincinnati Glee Club for entertaining so pleasantly at the Annual Banquet.

3. *Resolved*, That the Association express its appreciation to its President, Dr. John C. Whitehorn, for his enlightened leadership during a year of outstanding progress.

4. *Resolved*, That this Association record its gratitude to the other officers, to the members of Council, to the chairmen and members of the several Committees, and to the Affiliate Societies for their substantial contributions.

5. *Resolved*, That special thanks be voted to Dr. Thomas A. Ratliff, Chairman of the Committee on Arrangements, and to his fellow committee members for the efficient manner in which they discharged their duties; and that the Association express its particular thanks to Dr. Aurelia P. McIntyre and to her associates of the Women's Arrangements Committee for the entertainment accorded the lady guests of the Association.

6. *Resolved*, That the Association commend Dr. David A. Young and his fellow members of the Program Committee for the diverse and stimulating range of material set before the various sections.

7. *Resolved*, That the Association express its appreciation to Dr. Daniel Blain, Medical Director, to Mr. Austin M. Davies, Executive Assistant, and to their office staffs for their devotion to duty throughout the year.

8. *Resolved*, That the Association again commend Dr. Clarence B. Farrar for his service as Editor of the AMERICAN JOURNAL OF PSYCHIATRY.

9. *Resolved*, That the Association express its appreciation to the Cincinnati hotels, which have provided friendly and hospitable services to our members and guests.

10. *Resolved*, That the thanks of the Association again be extended to the members of the Press for their objective reporting of these proceedings.

11. *Resolved*, That the members of this Association take official cognizance of the fact that our scientific conclaves need not be painful, ponderous, and pontifical, as was aptly demonstrated at this, the 107th Annual Meeting of The American Psychiatric Association.

Respectfully submitted,
NEWTON BIGELOW, M. D.,
GASTON LOIGNON, M. D.,
BENJAMIN H. BALSER, M. D., *Chairman*.

The report of the Committee on Resolutions was duly approved.

The Secretary then reported important actions taken by Council at its meeting on May 10, 1951. This report, which was duly accepted by the membership, appears separately as a part of these Proceedings. Dr. John C. Whitehorn presented the gavel of office of the Association to Dr. Leo H. Bartemeier, who assumed the Presidency of the American Psychiatric Association.

The 107th annual meeting of the Association was adjourned.

LIST OF DECEASED MEMBERS AS READ AT THE 1951 ANNUAL MEETING

Charles L. Allen, Los Angeles, Calif.	Died May 28, 1946
George C. McDaniel, Topeka, Kan.	Died July 12, 1946
Frank L. Whelpley, Goldsboro, N. C.	Died Sept. 7, 1947
Charles Kleiman, Orangeburg, N. Y.	Died Nov. 20, 1947
Arturo O. Vivando, Santiago, Chile	Died May 6, 1949
William D. Stancil, Jr., San Francisco, Calif.	Died June 2, 1949
Robert S. Carroll, Asheville, N. C.	Died June 26, 1949
Benjamin W. Baker, San Antonio, Texas	Died Aug. 17, 1949
Steven G. Julay, New York, N. Y.	Died Sept. 5, 1949
Alfred C. Kingsley, Phoenix, Ariz.	Died Sept. 6, 1949
Robert P. Winterode, Crownsville, Md.	Died Sept. 19, 1949
Wilmer L. Allison, Fort Worth, Texas	Died Oct. 21, 1949
Clarence M. Kelley, Waverley, Mass.	Died Nov. 7, 1949
A. P. Goff, Cameron Mills, N. Y.	Died Nov. 8, 1949
Charles E. Nixon, Bakersfield, Calif.	Died Dec. 25, 1949
Johann G. Auerbach, New York, N. Y.	Died Jan. 20, 1950
Archibald A. Barron, Charlotte, N. C.	Died Feb. 8, 1950
John C. Barton, Bethesda, Md.	Died Feb. 12, 1950
Louis J. Spivak, Houston, Texas	Died Feb. 22, 1950
Andrew W. O'Malley, Clark's Summit, Pa.	Died Mar. 11, 1950
Harry R. Reynolds, Battle Creek, Mich.	Died Jan. 18, 1950
Walter M. Pamphilon, Jackson Heights, N. Y.	Died Mar. 29, 1950
George M. Lucas, Jacksonville, Ill.	Died April 1, 1950
William Ravine, Cincinnati, Ohio	Died April 11, 1950
William T. Hanson, Wakefield, Mass.	Died April 28, 1950
Charles F. Davis, St. Cloud, Minn.	Died May 7, 1950

Horatio M. Pollock, Albany, N. Y. ..... Died May 8, 1950
Trigant Burrow, Westport, Conn. ..... Died May 24, 1950
Johan H. van Ophuijsen, New York, N. Y. ..... Died May 31, 1950
Miriam F. Dunn, Washington, D. C. ..... Died June 5, 1950
Glenn E. Myers, Los Angeles, Calif. ..... Died June 11, 1950
E. H. Alderman, Richmond, Va. ..... Died June 27, 1950
Robert Wolf Biach, Fort Worth, Texas ..... Died July 1, 1950
Henry M. Pfeiffer, New York, N. Y. ..... Died July 11, 1950
Edward F. Reaser, Huntington, W. Va. ..... Died July 18, 1950
John M. Schimmenti, San Francisco, Calif. ..... Died July 19, 1950
Charles C. Burlingame, New York, N. Y. ..... Died July 22, 1950
Garland H. Pace, Salt Lake City, Utah ..... Died July 24, 1950
David Fogel, Los Angeles, Calif. ..... Died Aug. 12, 1950
John W. Ballard, New Castle, Del. ..... Died Aug. 18, 1950
Julius S. Alexander, Peoria, Ill. ..... Died Aug. 19, 1950
Wilfred McKechnie, Branson, Mo. ..... Died Aug. 27, 1950
Ruth Foster, New York, N. Y. ..... Died Sept. 1950
August Sauthoff, Mendota, Wis. ..... Died Sept. 19, 1950
J. William Beckman, New York, N. Y. ..... Died Sept. 8, 1950
James H. Benton, Fort Worth, Texas ..... Died Sept. 16, 1950
Jerry C. Price, New York, N. Y. ..... Died Sept. 24, 1950
Fritz Wittels, New York, N. Y. ..... Died Oct. 16, 1950
Paul C. Dane, Victoria, Australia ..... Died Dec. 1, 1950
H. A. Reye, Detroit, Mich. ..... Died Dec. 6, 1950
Lewis Thorne, New Haven, Conn. ..... Died Dec. 8, 1950
Dominic T. Ciolli, Buffalo, N. Y. ..... Died Dec. 22, 1950
Samuel R. Baker, Lexington, Ky. ..... Died Jan. 18, 1951
Lennard W. Wiren, Detroit, Mich. ..... Died Jan. 18, 1951
William T. Shanahan, Sonyea, N. Y. ..... Died Jan. 26, 1951
Marcel Pahmer, New York, N. Y. ..... Died Feb. 11, 1951
Douglas A. Thom, Boston, Mass. ..... Died Feb. 23, 1951
William L. Russell, New York, N. Y. ..... Died Mar. 31, 1951
Rodney R. Williams, Dobbs Ferry, N. Y. ..... Died April, 1951
Samuel R. Moreno, Mexico City ..... Died April, 1951

SUMMARY OF MEETINGS OF COUNCIL AND EXECUTIVE COMMITTEE JUNE 18, 1950, TO MAY 10, 1951

This report is of necessity limited to a brief summary of the principal activities and important actions of the Executive Committee and the Council. It is hoped that its brevity will interest many members who might otherwise ignore it.

No reference is made to the many routine matters that require attention at every meeting. Only activities and actions of the Executive Committee that do not require the approval or action of Council are reported, since such matters are reported from Council.

Executive Committee Meeting, June 18, 1950.—Voted to honor certain bills incurred at the 1950 Annual meeting and charge them against the Committee incurring them. Requested Dr. Leo H. Bartemeier to act as liaison with the American Psychoanalytic Association. Appointed Dr. Charles C. Burlingame as Publicity Representative for the APA in the U. S. for the International Congress of Psychiatry in Paris, and Dr. M. P. Torre as liaison officer between the Planning Commission in Paris prior to the Congress. Decided that Chairmen desiring to attend Executive Committee meetings should secure permission from an officer. Received a report from Dr. Blain of the progress of protest to the Civil Service Commission regarding examinations for clinical psychologists.

Approved President Whitehorn's reply to the Columbia Law Review concerning the licensing of clinical psychologists, and requested the Medical Director to publish this for the information of the membership. Voted disapproval of a special subscription rate to the JOURNAL for psychiatric aides. Requested the officers to prepare a Manual of Procedure. Voted approval for the Chairman of the Committee on Public Education and Relations to write a letter to the Editor of LOOK Magazine expressing disapproval of the article entitled "The Case Against Psycho-analysis," and expressing regret that the magazine did not secure available guidance of the APA before publishing such an article. Received a progress report of the Conference on Psychiatric Education to be held in June 1951.

Executive Committee Meeting, September 17, 1950.—Received the report of the *ad hoc* Committee appointed to study the Constitution of the NAMH as follows: "It is the opinion of this Committee that the professional interests and activities of the NAMH will be under the direction and guidance of a psychiatrist and that provision is made for the professional review and advice on all activities whether distinctly medical or related to education, finance, fund raising and others."

At the request of the Director of the Commission on Chronic Illness, asked Dr. Potter and Dr. Blain to select members to serve as experts on psychiatry in planning a conference on the Preventive Aspects of Chronic Disease. Received the announcement that Dr. Reynold Jensen and Dr. Blain would be official delegates of the APA to the Mid-Century White House Conference on Children and Youth. Voted adjustment of salaries of certain staff members working on projects financed by funds from the Commonwealth Fund, such increases to be paid out of moneys in this fund.

Voted approval of a plan to secure Workman's Compensation Insurance for employees of the Washington Office. Received announcement of the appointment of Dr. Leo Bartemeier as delegate and Drs. Eugene Ziskind, Gregory Zilboorg, Phyllis D. Schaefer, Herbert Holt, and Col. John Caldwell as observers at the meeting of the World Federation for Mental Health in Paris, August 1951. Received the report of the Executive Assistant that permanent steel files had been purchased for the preservation of all biographical data.

Executive Committee Meeting, November 5, 1950.—Received the report of the Committee on Legal Aspects of Psychiatry on its study of a model Act for State Commitment Laws, compiled by the Federal Security Agency. The Committee stated it was not in full accord with the model Act and had sent its criticisms to the FSA. Voted approval of the publication of the Report of the Committee on Leisure Time Activity if this could be accomplished within the appropriation for this Committee.

Received the report of the Membership Committee, and voted the acceptance of some eighteen resignations. Stated its opinion that each case of eliminating membership dues for those called into active military service should be considered individually by Council. Accepted the following suggested names to work with the Commission on Chronic Disease in planning a conference on Preventive Aspects of Chronic Disease: Drs. Morris Herman, Henriette Klein, Mark Kanzer, Max Weissman, Howard Potter, and Daniel Blain.

Council Meeting, November 6, 1950.—Voted to hold the 1952 Annual Meeting in Atlantic City and the 1953 Annual Meeting on the West Coast. Approved all actions of the Executive Committee at its meeting on June 18, 1950, September 17, 1950, and November 5, 1950. Adopted the policy that Council must approve payment of expenses and honorarium to speakers participating in scientific programs at the Annual Meetings. The principal speaker shall receive, out of Annual Meeting funds, traveling expenses and an honorarium of $100.

Approved a recommendation of the Executive Committee that the Medical Director be given authority to establish Regional Conferences, the money to be advanced from moneys in his budget and repaid out of registration fees. Voted additional contributions of 80,000 francs each from the U. S. and Canadian Committees to the International Congress of Psychiatry for the period of time up to and including the dates of the Congress held in September, 1950. Accepted as a progress report the draft of proposed organizational relations between the APA

and District Branch and Affiliate Societies prepared by Dr. D. Ewen Cameron and amended by the Executive Committee.

Voted approval of the President's statement to the National Academy of Sciences concerning a formulation of a plan for the best use of scientific and specialist personnel for the National Defense as follows:

1. Urged a policy of discriminating use of scientific manpower in order to insure at least a minimal continuation of the development of personnel with special skills.

2. Advised authority in some board to establish, for Selective Service, special categories of deferment for special training.

3. Suggested that the National Security Resources Board set up a specific agency for the scientific roster and the allocation of scientific and specialist personnel. With respect to psychiatrists, such roster could be set up in categories according to training and experience.

4. Suggested that some formula be made for the equitable distribution of psychiatrists in the armed forces and for hospital and clinic needs at home.

Voted to recommend to the Association the establishment of the Ohio Psychiatric Association as a District Branch. Elected Dr. Samuel Hamilton to the Editorial Board of the AMERICAN JOURNAL OF PSYCHIATRY to fill the vacancy created by the death of Dr. Charles C. Burlingame. Approved the recommendation of the Executive Committee that the Medical Director be permitted to enlarge gradually the Mental Hospital Service Bulletin and to accept carefully selected advertising, and that a committee be appointed to study the question.

Received the report of the Committee on Clinical Psychology, which was a resolution concerning psychiatric safeguards in the practice of psychotherapy by nonmedical psychotherapists. Because of a request from the Veteran's Committee that no action be taken on this matter until this Committee could complete its study of the problem, the resolution was referred back to the Committee on Clinical Psychology with the suggestion that it confer with members of Council and with the Committees on Veterans and on Legal Aspects of Psychiatry.

Adopted the following recommendations of the Committee on Nomenclature and Statistics:

1. That the revised psychiatric nomenclature be adopted as official by the APA.

2. That Council recommend this nomenclature for inclusion in the next revision of *Standard Nomenclature*.

3. That the Committee be authorized to prepare and publish a Diagnostic and Statistical Manual to replace the present one.

Adopted the following recommendations of the Central Inspection Board:

1. That all reports of inspections by the CIB sent to the state mental health authorities be made public after three months.

2. That the CIB be permitted to appeal for funds from states where inspections have been made.

3. Authorizing the President to receive moneys for the emergency support of the CIB.

Council later approved Executive Committee action authorizing the CIB to charge a fee to the states for inspection and rating service for a period of 2 years, subject to the approval of the NAMH and other interested groups, and voted that the Treasurer might expend for the CIB account moneys received from gift or fee.

Voted to request funds from the U. S. Public Health Service for a second Conference on Psychiatric Education in cooperation with the Association of American Colleges and other groups, and voted that Dr. John C. Whitehorn be chairman of this Conference. Referred for further study, by the Committee on Therapy and the Committee on Public Education and Relations, a resolution of the New Jersey Neuropsychiatric Association condemning the practice of "Dianetics." Later Council approved action of the Executive Committee in refusing to accept a challenge from the Hubbard Dianetic Research Foundation to a test between the APA and proponents of "Dianetics" on the basis that it is not the function of the APA to test hypotheses.

Authorized the use of surplus funds of the Association to pay a deficit in the JOURNAL account. Adopted a recommendation of the Budget Committee that the President appoint a committee to study and recommend personnel policies. Adopted two other recommendations of the Budget Committee:

1. That all items of income or expenditure from any source come before the Budget Committee for consideration and recommendation to Council.

2. That only items directly related to the administration and maintenance of the offices of the Medical Director and Executive Assistant be included in their respective budgets.

Voted that copies of Council Minutes be sent to the Chairmen of Coordinating Committees so that they may transmit word of any action affecting the work of a committee involved. Adopted a recommendation of the Coordinating Committee on Technical Aspects of Psychiatry that action in regard to committee reports by Council should designate such reports as "Received" if they require no action and "Approved" if action is taken.

Adopted a resolution of the Committee on Military Psychiatry authorizing the President of the APA to initiate the making of a complete roster of all psychiatrists in the U. S. and Canada with detailed information about each for the use of the armed forces, and authorizing him to raise, receive, and expend moneys for this project. Voted that the Secretary should give all needed advice and help to members who wished to propose amendments to the Constitution so that they will be presented in accordance with Constitutional requirements.

Executive Committee Meeting, January 7, 1951. —Voted to accept invitation of the War Claims Commission for representation on the Special Advisory Committee, and requested the President to appoint such representative. Voted that the Association communicate officially with officers of international meetings advising the names of all APA

members who will attend, to give credentials only to official delegates. Received the announcement of the appointment of Dr. Frederick R. Hanson as Chairman of the new *ad hoc* Committee on Civilian Defense and Dr. J. S. Tyhurst and Dr. Dale C. Cameron as members.

Requested the Committee on Military Psychiatry to consider further the most effective way of influencing action on the use of the term "homosexuality" in army regulations. Voted to hold meetings of all committees in New York City on March 10 and 11, and to finance the expense of these meetings out of Commonwealth fund for committee project.

Executive Committee Meeting, January 20-21, 1951.—Received information that a letter from the Chairman of the Civil Service Commission stated that when reannouncement of examination for clinical psychologists is contemplated, the Commission will take cognizance of the wishes of the APA as to content. Requested the Committee on Budget to study the financial problems of the Association that may be anticipated should the U. S. become involved in a general mobilization. Received the announcement of the appointment of Dr. James H. Wall, as Chairman, and Dr. George S. Stevenson to serve on an *ad hoc* Committee to formulate personnel practices and policies.

Received the announcement of the appointment of Dr. Zigmond M. Lebensohn as APA representative on the Special Advisory Committee to the War Claims Commission. Expressed approval of a letter presented by Dr. Bloomberg, Chairman of the Committee on Public Education and Relations, which he plans to use as a model in informing magazines and newspapers of the services of his Committee in reviewing proposed articles on psychiatry. Voted not to publish the daily Bulletin this year at the Annual Meeting. Accepted the invitation to become a cooperating Association in the Second Gerontological Congress to be held at St. Louis, September 9-14, 1951.

Voted that the Association contribute $50.00 to the National Health Council, subject to approval of the Budget Committee. Received announcement of the appointment of Drs. Winfred Overholser, Lauren Smith, and E. E. Landis as delegates to the National Health Council, and the appointment of Dr. Daniel Blain to the Nominating Committee of the National Health Council for nomination of members of Board of Directors of the Council.

Received announcement of appointment of Dr. Daniel Blain and Dr. Howard Potter as APA representatives to the Conference on the Preventive Aspects of Chronic Diseases.

Executive Committee Meeting, March 9, 1951.—Studied and revised the fourth draft of the Manual of Organization and Policy, as presented by Dr. Whitehorn and Dr. Blain. Voted approval of the publication of a "Survey of Psychiatric Nursing Personnel," compiled by the Nursing Consultant, from available funds of the Committee on Psychiatric Nursing.

Council Meeting, March 10, 1951.—Approved all actions of the Executive Committee taken at its meetings on January 7, 1951, and March 9, 1951. Approved action of the Executive Committee in authorizing the *ad hoc* Committee on Civilian Defense, to seek necessary funds for publishing a Manual on Civilian Defense, and giving the President power to authorize such publication along with referees from Council.

Voted that Mr. Austin H. Davies be designated as Business Manager of the JOURNAL and requested to make continuing studies of potential sources of income and possible savings in cost of the JOURNAL. Studied and further revised the fourth draft of the Manual of Organization and Policy. Voted to empower Dr. Blain to proceed with negotiations for lease of new offices for the Washington Office. Confirmed the appointment of Miss Elsie Ogilvie of Montreal as Nursing Consultant.

Council Meeting, May 5, 1951.—Voted approval of certain amendments to the Constitution, some originating by petition of members and others by resolution of Council. (All proposed amendments were read by the Secretary to the membership, and have since been sent to the membership for vote by mail ballot.) Voted favorable consideration of the request of the Mid-Continent Psychiatric Association, a District Branch of the APA, to extend its geographical boundaries to include the state of Oklahoma. Voted to recommend to the membership the application of the Arkansas Society for affiliation with the APA. Recommended to the membership final acceptance of the societies provisionally accepted as affiliates of APA by Council in May 1950. They are: Long Island Psychiatric Society, Nassau Neuropsychiatric Society, Southeastern Society of Neurology and Psychiatry, Bronx Society of Neurology and Psychiatry, and Oklahoma Society of Psychiatry and Neurology.

Approved action of the Executive Committee in an emergency appropriation of $400 for a meeting of the *ad hoc* Committee on Civilian Defense from unallocated funds of the Association. Voted Dr. David Boyd as representative of the APA to the American Board of Psychiatry and Neurology to replace Dr. Karl Bowman. Voted dates of next Annual Meeting in Atlantic City to be May 12 through 16, 1952. Elected Drs. Jacques Gottlieb and Harold Wolff as new members of the Hofheimer Prize Board. Instructed the Program Committee to report to Council those Sections which fail to report their programs to the Committee by November 1, 1951.

Approved the principles for the guidance of supervising psychiatrists as presented by the Committee on Clinical Psychiatry and contained in the report of the Coordinating Committee on Professional Aspects of Psychiatry. Authorized the Committee on Psychiatric Hospital Standards and policies to formulate standards for mental hygiene clinics and for psychiatric departments in general hospitals. Approved for release the material contained in the letters on "Adolescence" and "Discipline" in the form in which it now exists as a statement from the Committee on Academic Education to the membership.

Approved the recommendations of the Coordinating Committee on Community Aspects of Psy-

chiatry that "communications which do not express personal or committee opinion (for example, bibliographies, statistical material, etc.) do not require approval of Council for general distribution, but can be done with authorization of the President through the Medical Director." Approved the *Manual of Organization and Policy of the APA* and authorized its publication. Voted to submit to advisory referendum by mail to the membership certain questions regarding the consolidation and the location of the Association offices.

Council Meeting, May 10, 1951.—Approved the following recommendations of the Committee on Committees: That the Committee on Alcoholism and the Committee on Therapy give consideration to the merger of these two committees; That no change be made in the size of any committee except the Committee on Public Education and Relations, which will be reduced to 6 members; That all standing committees, except housekeeping committees, hold a meeting, open to members of the Association, during the next Annual meeting. Disapproved the recommendation of the Committee on Committees to merge the Committee on Preventive Psychiatry and the Committee on Leisure Time Activity into a single Committee on Mental Health.

Approved the following appointments to the Committee on Membership: Dr. Robert O. Jones, Chairman, Dr. Riley H. Guthrie, Dr. Herbert S. Gaskill, Dr. Douglas W. Orr, Dr. Alexander Simon, and Dr. David C. Wilson.

Elected the incoming President, Dr. Leo H. Bartemeier, as Moderator of the Council. Voted that the budget year remain as it is, July 1 to June 30. Authorized expenditures for the coming year in accordance with the recommendations of the Budget Committee as amended. Elected Drs. George S. Stevenson and Francis J. Braceland to membership on the Executive Committee.

Voted that the Budget Committee be added to the list of housekeeping committees referred to on p. 295 of the Proceedings of the Association as published in the October 1950 issue of the JOURNAL. Approved the report of the Central Inspection Board as presented by Dr. Ralph M. Chambers. Endorsed the publication of the report of the Committee on Academic Education entitled "Mental Health in Education." Approved the following recommendations of the Committee on Veterans:

1. Opposition to the independent practice of psychotherapy by clinical psychologists save under close supervision of a psychiatrist.

2. Stabilization of the financial program for the professional care of the ill veteran—subject to editorial revision to bring them into line with previous Council action.

3. Requested the Medical Director, with the aid of the Committee on Veterans, to perform this editorial revision for presentation to the Veterans Committee.

R. FINLEY GAYLE, JR., M. D.
Secretary

REPORT OF TREASURER FOR THE PERIOD APRIL 1, 1950–MARCH 31, 1951

The honest concern many members of the APA are showing about the Association's financial affairs is a healthy manifestation of member responsibility. They are asking many questions about our Association's financial affairs. How much of an income is available for the Association to live on? Are we spending within our income and for what? Are our expenditures exceeding our income and, if so, are these expenditures wisely made? Where do we stand in relation to our fluid reserves? Are we depleting our reserves year by year by a process of attrition, and, if so, must this go on or when may we expect income to exceed expenditures? If we must economize on expenditures, where shall we begin?

You, each of you, may find an answer to some of these questions, and to yet others that I have not formulated in the following report. This report, as has been my custom in the past, is based on the professional accountant's report of his audit of the books and accounts of the Association for the period April 1, 1950, to March 31, 1951. As a matter of simplification I am reporting in round numbers using the nearest one in hundreds to the actual figures in the professional accountant's report.

Although the Association receives a number of foundation grants for special projects, to which I shall refer later, its financial life blood is derived from specific sources. From April 1, 1950, to March 31, 1951, the treasury received from the following sources the following amounts:

Source	1950-51	1949-50	Excess over 1949-50
Membership dues	$111,800	$104,000	$7,800
Mental hospital institute, mail pouch, stipends, and others, Med. Directors office	21,200	11,100	10,100
Subscription to and advertising in JOURNAL	34,500	32,500	2,000
Biographical directory	7,100	6,200	900
Annual meeting	21,800	21,500	300
Miscellaneous	4,500	4,700	(—200)
TOTAL INCOME	$200,900	$180,000	$20,900

It is a bit heartening to all of us, I am sure, that our income was close to $21,000 more than in the fiscal year ending March 31, 1950. But before we

become too exuberant over this, let us look into how much we spent and for what.

During the 1950-51 fiscal year, by fiat of the Council, your treasurer paid out the following sums of money on vouchers chargeable against the Association's activities listed as follows:

	1950-51	1949-50	Differential Increase	Differential Decrease
Committee and Council activities (includes mail ballot and mandatory item of $7,500 for Committee on Psychiatric Nursing)..	$25,200	$20,600	$4,600	
Medical Director's activities.....	55,200	50,300	4,900	
Executive Assistant's activities.....	32,000	33,100		$1,100
Editing, printing, and distributing JOURNAL..	47,200	63,600		16,400
Editing, printing, and distributing Biographical Directory.....	13,950	8,400	5,550	
Annual Meeting.....	21,450	23,000		1,550
TOTAL	$195,000	$199,000	$15,050	$19,050
Decrease in expenditures.....				$4,000

Now to recapitulate: during the fiscal year ending March 31, 1951, the Association's treasury received nearly $201,000 ($200,900) that could be applied against its day-to-day operating expenses; this was nearly $21,000 better than the take of the year before. During the fiscal year ending a little over a month ago today, the Association carried on its affairs, exclusive of some specially financed projects, at a cost of $195,000, a figure nearly $6,000 ($5,900) under its income for the same period. Last year we spent about $19,000 in excess of income.

Now a few comments about our resources: A year ago I reported to you that the Association owned $18,000 worth of U. S. and Canadian Government bonds, and had approximately $28,000 in cash savings and checking accounts, making a total backlog of some $46,000. On March 31, 1951, we still owned the $18,000 worth of U. S. and Canadian Government Bonds and we had, after deducting unpaid vouchers carried over into the new fiscal year (1951-52), some $34,200 in savings and checking accounts, giving us a backlog of a little over $52,000 with which to start the current year. Hence in terms of fluid or cash resources, we are some $6,000 better off than we were a year ago. The Association has unassessed resources in the form of office furniture, files, office equipment, unsold copies of the biographical directory and other such material that have never been systematically inventoried. The stock of biographical directories alone represents a potential income of over $20,000 if sold at the current price per volume.

I should review, briefly, for you the matter of special grants; there are 6 of them, which may be listed as follows:

1. The Rockefeller grant for the work of the Committee on Psychiatric Nursing. It became effective July 1, 1947, when $25,000 was earmarked by the Rockefeller Foundation for the Association with an agreement that the work of the Nursing Committee would be supported at the rate of $10,000 per year for 5 years. The Rockefeller Foundation agreed to make available $10,000 the first year, $7,500 the second, $5,000 the third and $2,500 the fourth; the Association agreed to appropriate an amount each year from its treasury to carry on the work of the Committee on Nursing at a $10,000 budgetary level. This grant expires June 30, 1951. There is a balance of $4,100 in this account.

2. The National Association for Mental Health grant (formerly the Psychiatric Foundation grant) for the work of the Central Inspection Board. This grant, which became effective February, 1947, is not guaranteed as to amount nor is it stated that it will run for any specified period of time. Its continuation appears to depend on the financial resources of the National Association for Mental Health and the good will of its Board. The NAMH is currently sending the APA $2,250 per month for the support of the work of the Central Inspection Board. As of March 31, there was $390.14 in this account.

3. The Commonwealth Fund grant for the Mental Hospital Service. This is a grant of $44,500 that became effective January 1, 1950, for establishing an informational, educational, and advisory service through the medium of a monthly publication under the supervision and guidance of the Medical Director. The grant was made with the hope that such a mental hospital service could become self-financing. The grant terminates December 31, 1951. As of March 31 there was $10,287.38 in this account.

4. The Commonwealth Fund grant for the study of APA committee structure and function. A grant of $20,000 that became effective January 1, 1950, for 1 year has since been renewed for 1 year, terminating December 31, 1951. It has been used to bring together, once a year, the APA committees. Its administration has been the responsibility of the Medical Director and an *ad hoc* Committee on Committees.

5. The United States Public Health Service grant for a teaching conference. This grant of $58,300 became effective July 1, 1950, and will terminate June 30, 1951. Its purpose is to support a carefully planned conference on psychiatric education in collaboration with the Association of American Medical Colleges. The grant is administered by the President, Dr. John C. Whitehorn, as Chairman of the project, assisted by the Medical Director. As of March 31, there was $42,633.10 in this account.

6. On April 14, 1951, this grant was extended to October, 1952, with an additional sum of $62,636 to hold a further conference on graduate and postgraduate psychiatric education.

The third and last section of this report concerns itself with certain well-defined projects financed out of the general funds of the Association. These are as follows: the AMERICAN JOURNAL OF PSYCHIATRY, the Biographical Directory, the Newsletter and Mail Pouch, the Mental Hospital Institute, Training Seminar, and Regional Research Conference.

1. AMERICAN JOURNAL OF PSYCHIATRY.

For bookkeeping purposes, we carry a separate account for the JOURNAL. Credited to this account are receipts from subscriptions and advertising, sale of back numbers and reprints, and funds allocated from the general account. Charged against this account are all costs of editing, printing, and distribution.

During the year ending March 31, 1951—	
Receipts from	
Subscriptions	$18,500
Advertising	15,100
Sale of reprints and back numbers	700
Allocated from general account	18,000
Miscellaneous	200
Total	$52,500
Cost of editing, printing, and distributing	47,200
Excess receipts over expenses	$5,300

On analyzing these figures we find that the receipts from sources other than the general fund amounted to $33,600 or 71% of the cost of the JOURNAL, leaving 13,600 to be financed out of membership dues, a matter of $2.33 per member, based on a membership of 5,856.

2. The Biographical Directory.

The total cost for editing and printing the biographical directory comes to $29,500. As of March 31, 1951, the sale of the Directory had brought in $13,300, leaving a deficit as of this date of $16,200. There are nearly 2,100 copies of the Directory in stock, which have an inventory value, based on the current selling price of $12.00 per volume, of $25,200.

3. The Newsletter and Mail Pouch.

During the fiscal year ending March 31,1951, the receipts came from the following sources—

Fees for use of Mail Pouch	$4,300
Subscription to Newsletter	300
Total	$4,600

Expenditures for editing, printing, and distributing the Newsletter through the Mail Pouch during the same period were as follows:

Distribution of the contents of the Pouch:	
Printing and preparation of the Newsletter	$1,150
Operation of Pouch including distribution of Newsletter	2,950
Total	$4,100
Excess of receipts over expenditures	—$500.00

4. Mental Hospital Institute.

Mental Hospital Institutes were initiated during the 1949-50 fiscal year. Receipts accrue from registration fees and sale of published proceedings. Since the initiation of the Institutes and up to March 31, 1951, receipts are reported from—

Registration	$18,750
Sale of proceedings	4,700
Total	$23,450

Expenditures, during the life time of the Institutes up to March 31, 1951, amounted to $22,000, which includes cost of editing and printing the proceedings of two Mental Hospital Institutes.

The Mental Hospital Institutes, as of March 31, 1951, have been self-supporting since receipts have exceeded expenditures by $1,450. There are 500 copies of the Proceedings on hand, which have a book value of $1,000.

5. The Training Seminars.

The first training seminar was held in conjunction with the Association's annual meeting in Montreal in 1949. Training seminars are dependent on their support on registration fees. Receipts from the Montreal and Detroit seminars came to $1,200. Expenses in connection with these amounted to $1,700. The deficit of $500 had to be made up from the Association's general fund.

6. Regional Research Conference.

The first such conference has been held and the Treasurer has not been asked to pay any bills. The conference was run on the policy that all would pay their own expenses. The University with which we cooperated furnished some secretarial help and the Medical Director's office added some promotional work and secretarial assistance.

In conclusion, I feel that I should add a personal note of appreciation of the determination of the Budget Committee, the Council, the Executive Committee, and the President to bring our financial structure into balance; that these efforts have been rewarded is evidenced by this report.

HOWARD W. POTTER, M.D.

REPORT OF THE BUDGET COMMITTEE

To the President and Members of the Council

your Committee on Budget has the honor to submit herewith an estimate of income and expenditures for The American Psychiatric Association for the year July 1, 1951, through June 30, 1952.

All anticipated income including funds received from grants and gifts are included in these estimates as are also all items of expenditure except the Hofheimer Award. This latter item was not estimated since this prize is awarded only on recommendation

of the Prize Board and by authorization of Council. It is not an annual expenditure. Your Committee has estimated income from all sources including grants at $374,406.00 and expenditures at $371,765.00. If experience bears out these estimates, the Association will realize an excess of income over expenditures of $2,641.00 for the coming budget year.

Your Committee wishes to invite the attention of Council to several facts concerning the budget and to submit recommendations for their consideration.

Two items of income must be considered as somewhat speculative. These items are $27,000 from the National Association for Mental Health for the Central Inspection Board and $35,000 from subscriptions to the Mental Hospital Service and Institute.

If for any reasons these two items of income appear to be in jeopardy the Council should instruct its paid staff so to inform them so that Council or the Executive Committee can take whatever action seems appropriate. The Budget Committee points out for emphasis the fact that as presently constituted the Association is obligated to bear the expenses of these two services for the budget year, July 1, 1951-June 30, 1952, from whatever funds are available to the Association. Whether the Council wishes to bear this expense irrespective of income from these two sources is a matter of policy to be determined by Council and not by the Budget Committee. For emphasis, the Budget Committee again points out that, should no income accrue to the treasury from these sources and if the expenses are borne through the budget year, it will exhaust the total reserves of the Association.

The Budget Committee further wishes to point out that the expenses of these two activities will continue until such time as the Council discontinues them by official action; no action short of this by the Council such as a directive to the Treasurer to desist from the payment of obligations against these activities will relieve the Association from its financial responsibilities.

Attention is invited to the budget estimate for committee expenses that contains a new item entitled "Emergency Funds for Council." This item was included with the hope that a significant portion of it will revert to Surplus.

Attention is also called to the footnote referring to the budget estimate for the Committee on Nursing. The staff informed your Committee that owing to salary lapses due to an unfilled vacancy in this item there will be an unexpended balance of $1,500 or thereabouts for the current budget year. It is recommended that the Rockefeller Foundation be requested to reappropriate its share of this unexpended balance to the Association.

Over the past 3 years your Committee has encountered considerable difficulty in formulating budget estimates during the Annual Meeting. There are a variety of reasons for this. It is recommended that Council instruct the Budget Committee to prepare budget estimates to cover the fiscal year, April 1 through March 31, and submit this to Council at its midwinter meeting. It is further requested in order that the Committee may prepare this budget that the staff of the Association be instructed to prepare its budget estimates in sufficient time to have them in the hands of the Budget Committee by December 1 of each year.

CLARENCE H. BELLINGER,
JACK R. EWALT,
LAWSON W. LOWREY,
WINFRED OVERHOLSER,
FREDERICK W. PARSONS,
HOWARD W. POTTER (*ex officio*),
ROBERT H. FELIX, *Chairman.*

ANTICIPATED INCOME

I. GENERAL ACCOUNT*	$149,850.00	
II. GRANTS	146,856.00	
III. MEDICAL DIRECTOR'S OFFICE	7,000.00	
IV. MENTAL HOSPITAL INSTITUTES AND SERVICE	35,000.00	
V. AMERICAN JOURNAL OF PSYCHIATRY	35,700.00	
TOTAL ANTICIPATED INCOME		$374,406.00

* Includes income from Annual Meeting Account.

APPROPRIATIONS FOR EXPENDITURES

I. MEDICAL DIRECTOR'S OFFICE	$ 60,500.00	
II. GRANTS AND SPECIAL ACTIVITIES	144,669.00	
III. EXECUTIVE ASSISTANT'S OFFICE	31,552.00	
IV. AMERICAN JOURNAL OF PSYCHIATRY	51,944.00	
V. COMMITTEE EXPENSES	33,600.00	
VI. ANNUAL MEETING ACCOUNT	22,500.00	
VII. CENTRAL INSPECTION BOARD	27,000.00	
TOTAL APPROPRIATIONS		$371,765.00
SURPLUS		$ 2,641.00

ANTICIPATED INCOME

	50-51 Estimated		50-51 Actual		51-52 Estimated	
I. *General Account*						
Membership Dues	$116,000		$111,800		$120,000	
Sale of Membership and Fellowship Certificates	1,600		1,574		1,600	
Sale of Membership Lists	150		192		150	
Sale of Biographical Directory	11,000		7,128		4,500	
Rental of Space, N. Y. Office	2,000		1,450		200	
Interest on Bonds, etc.	800		887		900	
Annual Meeting Account	23,000		21,780		22,500	
Total		$154,550		$144,811		$149,850
II. *Grants*						
Psychiatric Foundation (Central Inspection Board)	27,000		33,949		.....	
National Association for Mental Health (Central Inspection Board)	.....		.....		27,000	
Rockefeller Foundation (Nursing Committee)	2,500		2,500		.....	
Commonwealth Fund (Mental Hospital Service)	22,000		34,645		10,287 †	
Commonwealth Fund (Committee Project)	1,000		20,000		4,300 †	
United States Public Health Service (Conf. #1)	.....		58,300		42,633 †	
United States Public Health Service (Conf. #2)	.....		.....		62,636	
Total		25,500		149,392		146,856
III. *Medical Director's Office*						
Sale of Committee Reports	50		.....		.....	
Honoraria and Speeches	750		672		.....	
Mail Pouch and Newsletter	4,500		4,290		5,000	
Training Seminar (April 30, 1950)	1,500		1,145		.....	
Regional Research Conference	2,000		‡		.....	
Conferences and Seminars	.....		.....		2,000	
Total		8,800		6,107		7,000
IV. *Mental Hospital Institutes and Service*						
Enrollments and Sale of Proceedings Mental Hospital Institute #2	7,500		14,833		14,500	
Subscriptions, Mental Hospital Service Bulletin	100		42		.....	
300 Hospital Subscriptions, $50 each	.....		.....		15,000	
Sale of Other Publications	.....		.....		2,500	
Carryover from preceeding year's budget	.....		.....		2,500	
Total		7,600		14,875		35,000
V. *American Journal of Psychiatry*						
Subscription	19,000		18,525		19,000	
Advertising	15,000		15,066		16,000	
Sale of Back Numbers	600		629		700	
Miscellaneous	.....		279		.....	
Transfer from Membership Account §	18,000		18,000		18,900	
Total		34,600		34,498		35,700
Grand Total		258,050		349,683		374,406

† Unexpended funds carried over from 1950-51 budget year.
‡ No expenses for project.
§ Transferred from Membership Account and not included in income total under this item.

APPROPRIATION FOR EXPENDITURES

	50-51 Estimated	50-51 Actual	51-52 Estimated	
I. Medical Director's Office				
A. Salaries:				
Medical Director	$15,000	$15,000	$15,000	
Asst. to Med. Director	....	....	8,000	
Office Manager	3,800	3,800	8,000	
Secretary	2,900	2,900	3,200	
Information Chief	6,300	6,300	3,800	
Asst. to Info. Chief	3,400	3,400	....	
Typist	....	....	2,600	
Typist	....	....	2,600	
Typist (6 Months)	....	....	1,300 ‖	
Telephone Girl	....	....	2,600	
Total—A	$31,400	$31,400		$43,100
B. Office Expenses:				
Rent and Utilities	2,500	3,122	2,700	
Telephone and Telegraph	1,200	1,523	1,500	
Postage	800	634	1,200	
Office Equipment	300	447	500	
Travel	1,000	1,710	1,500	
Misc. Expenses	150	484	500	
Office Supplies	1,000	3,001	2,500	
Total—B	6,950	10,921		10,400
C. Services:				
Newsletter and Pouch	5,500	4,014	5,000	
Conferences and Seminars	3,500	1,436	2,000	
Total—C	9,000	5,450		7,000
Grand Total—Medical Director's Office				$60,500
II. Grants and Special Activities				
Mental Hospital Service (See Exhibit A)			$30,500 ¶	
Mental Hospital Institutes			10,600	
Conference on Psychiatric Education (Exhibit B #1)			....	
Conference on Psychiatric Education (Exhibit B #2)			99,269 **	
Committee Project			4,300	
Total				$144,669

‖ This salary from Committee Project item below in Grants and Special Activities
¶ $2,000 additional carried as salaries in the Office of the Medical Director.
** $6,000 additional carried as salaries in the Office of the Medical Director.

Exhibit—A. Mental Hospital Service

Expenditures		
Salaries		
Chief Editorial Assistant	$4,000.00	
Administrative Assistant	3,400.00	
Editorial Secretary	2,800.00	
		$10,200.00
Publications		
Bulletin	3,600.00	
Proceedings, Hospital Institute	2,000.00	
Other pamphlets, reports, proceedings	3,000.00	
M. H. S. Film Service	3,000.00	
Statistical Manual	2,500.00	
		14,100.00
Other Expenses		
Addressographing	170.00	
Travel, M. H. S. Consultants	1,000.00	
Rent	780.00	
Telephone and Telegraph	500.00	
Postage, including for Bulletin	900.00	
Stationery and Office Supplies	600.00	
Contingent Operating Expenses		2,250.00
Total Expenditures		$30,500.00

EXHIBIT B—BUDGETS FOR FIRST AND SECOND CONFERENCES ON PSYCHIATRIC EDUCATION

	First Conference (Undergraduate) (As Revised, May 1, 1951)	Second Conference (Postgraduate)
Professional Personnel ..... Includes per diem consultation fees, part-time professional direction	$ 5,000.00	$10,000.00
Non Professional Personnel..... Includes administrative officers, secretarial help for executive office, executive committees, planning committees, etc.	13,500.00	15,136.00
Consumable Supplies ..... Includes office supplies, stationery, mimeographing, printing, postage, telephone, telegraph, etc.	5,000.00	3,500.00
Other Expenses ..... Includes provision for duplicating, typing, recording and other equipment and for conference stenotyping and reporting	3,250.00	3,000.00
Travel ..... Includes all travel for preparatory groups and conference members, as well as for staff and secretarial assistance	31,550.00	31,000.00
Totals	$58,300.00	$62,636.00

III. EXECUTIVE ASSISTANT'S OFFICE	50-51 Estimated		50-51 Actual		51-52 Estimated	
A. Salaries:						
Executive Assistant	$10,000		$10,000		$10,000	
Bookkeeper	3,620		3,825 *		3,380	
Assistant Bookkeeper	2,230		2,088 †		2,080	
Telephone Operator	2,178		2,178		2,178	
Two Secretaries ‡	4,120		3,705		....	
Temporary Help	600		246		500	
Totals		$22,748		$22,042		$18,138
B. Office Expenses:						
Rent	5,364		5,364		5,364	
Printing of Office Forms...	400		411		500	
Travel	500		385		500	
Utilities	150		150		150	
Office Supplies	350		600		650	
Telephone and Telegraph..	1,000		972		1,000	
Postage	1,000		969		1,350	
Totals		8,704		8,851		9,514
C. Publications:						
Biographical Directory ...	12,500		12,049		....	
Supplement to Membership Directory	1,500		833		1,700	
Fellowship Certificates	350		160		250	
Totals		14,350		13,042		1,950
D. Miscellaneous Items:						
Auditor	250		250		300	
Insurance	350		350		350	
Social Security Taxes, etc..	750		907		1,200	
Petty Cash	250		....		100	
Totals		1,600		1,507		1,950
Total, Executive Assistant's Office		47,462		45,442		31,552

* 7 months at $3,620 per annum and 5 months at $3,380 per annum.
† 9 months at $2,230 per annum and 3 months at $1,848 per annum.
‡ Worked on Biographical Directory.

IV. AMERICAN JOURNAL OF PSYCHIATRY						
A. Printing and Distribution (12 issues)	$36,000		$37,073		$40,000	
B. Advertising Commissions	3,500		2,297		2,700	
C. Salaries:						
Editorial Assistant	3,200		3,200		3,200	
Secretary, N. Y. Office	2,550		2,550		2,800	
Editorial Assistance	450		525		450	
Totals		6,200		6,275		6,450
D. Office Expense:						
Rent, Toronto Office	1,000		844		844	
Travel—Editor	200		80		200	
Rent, N. Y. Office	300		300		200	
Telephone and Telegraph	200		200		200	
Office Expense	500		455		550	
Printing, Office Forms	200		45		200	†
Postage	300		118		250	
Social Security Tax	70		83		100	
Miscellaneous	250		32		250	†
Totals		3,020		2,157		2,794
Total, AMERICAN JOURNAL OF PSYCHIATRY		48,720		47,709		51,044
V. COMMITTEES						
1. Executive Committee and Council	$ 9,250		$12,386		$10,000 §	
2. Academic Education	350		200		350	
3. Alcoholism	100		0		100	
4. Arrangements	0		0		0	
5. Budget	0		0		0	
6. Child Psychiatry	200		186		300	
7. Civil Defense	0		271		500 ‖	
8. Clinical Psychology	200		75		200	
9. Ethics	500		500		250	
10. History of Psychiatry ¶	0		0		0	
11. Industrial Psychiatry	300		0		300	
12. International Relations	300		375		300	
13. Legal Aspects	400		0		400	
14. Leisure Time	300		51		300	
15. Medical Education	1,000		39		500	
16. Medical Rehabilitation	200		156		200	
17. Membership	500		500		750	
18. Military Psychiatry	350		203		250	
19. Nomenclature and Statistics	900		1,163		500	
20. Nominating	250		200		400	
21. Preventive Psychiatry	100		64		100	
22. Program	2,000		763		2,000	
23. Standards and Policies	800		143		1,000	
24. Nursing	10,000		7,500		10,000 **	
25. Social Service	300		50		300	
26. Public Education and Relations	1,550		726		1,200	
27. Public Health	300		95		300	
28. Research	250		114		500	
29. Resolutions	0		0		0	
30. Therapy	200		90		200	
31. Veterans	300		120		400	
Contingent Fund for Committee Expense	1,750		1,750		....	
Emergency Fund for Council	....		....		2,000	
Total, Committees		$32,650		$27,724		$33,600
VI. ANNUAL MEETING	22,000		21,438		22,500	
VII. CENTRAL INSPECTION BOARD	27,000		33,950		27,000	

§ This includes $750.00 for cost of mail ballot.
‖ This is an ad hoc committee.
¶ This committee has $1,239.75 in restricted funds carried in a special fund.
** $1,500 of this item anticipated to come from reappropriation by Rockefeller Foundation of unexpended funds caused by salary lapses.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

In conformance with the request of the American Psychiatric Association, we are submitting the following account of the activities of the American Board of Psychiatry and Neurology, Inc., since the last report to the Association by letter dated April 5, 1950.

The Board consists at present of the following members:

Appointed by the American Psychiatric Association:

Dr. Kenneth E. Appel (term expires December, 1954).
Dr. Karl M. Bowman (term expires December 1951).
Dr. Francis J. Braceland (term expires December 1952).
Dr. George H. Stevenson (term expires December 1953).

Appointed by the American Neurological Association:

Dr. Bernard J. Alpers (term expires December 1951).
Dr. Roland P. Mackay (term expires December 1953).
Dr. S. Bernard Wortis (term expires December 1952).
Dr. Paul I. Yakovlev (term expires December 1954).

Appointed by the Section on Nervous and Mental Diseases of the American Medical Association:

Dr. Percival Bailey (term expires December 1951).
Dr. Russell N. DeJong (term expires December 1954).
Dr. Frederick P. Moersch (term expires December 1952).
Dr. George N. Raines (term expires December 1953).

At the annual meeting of the Board in December, 1950, the following officers were elected: Dr. S. Bernard Wortis, president; Dr. Kenneth E. Appel, vice-president; Dr. Francis J. Braceland, secretary-treasurer.

When the Board met in San Francisco, Calif., in June 1950, 256 candidates were examined. Of this number, the Board certified 131 in psychiatry, 19 in neurology and psychiatry.

The annual meeting of the Board was held in New York City in December 1950. At this time 370 candidates were examined by the Board. Of this number 211 were certified in psychiatry, 17 in neurology, and 3 in neurology and psychiatry.

Since its inception the Board has received 5,485 applications. Some of these are still under consideration. The total number of diplomas issued by the Board to date is 3,852. Of this number 2,684 received certification in psychiatry, 254 in neurology, and 914 in neurology and psychiatry.

Below is a summary of the financial status of the Board for the year 1950. An audit report is open to inspection in the Executive Offices of the American Board of Psychiatry and Neurology, Inc., and will be sent if requested. Unfortunately, we do not have enough copies for all concerned.

Receipts

Fees	$41,487.50
New Diploma Fees	40.00
Interest on Bond and Savings Account	300.12
Total Recipts:	$41,827.62

Disbursements

Office Expenses	$2,405.44
Office Salaries	5,490.25
Taxes	80.40
Examination Expenses	20,903.28
Special Meeting Expenses	157.18
Refunds	162.50
Miscellaneous	2,643.45
Total Disbursements	$31,842.50

F. J. Braceland, M. D.,
Secretary-Treasurer.

PRESIDENT'S PAGE

On May 21, 1951, the Council of the Association submitted to advisory referendum, by mail ballot of the membership, the question of consolidation of the New York and Washington offices for the purpose of efficiency and economy.

On June 15, the Board of Tellers met at the New York office of the Association, counted the ballots, and submitted the following results of their tabulation through Dr. Crawford N. Baganz, the Chairman of the Board:

Total number of ballots mailed	5633	
Total number of ballots returned	3562	(63.2%)
Total number of ballots favoring consolidation	3380	(96.02%)
Total number of ballots not favoring consolidation	140	
Total number of ballots cast for consolidation in New York	2115	(62.6%)
Total number of ballots cast for consolidation in Washington, D. C.	864	(25.5%)
Total number of ballots cast for Philadelphia	85	
Total number of ballots cast for Chicago	76	
Other cities	18	
Breakdown as follows:		
St. Louis, Missouri	4	
Los Angeles, California	2	
Cincinnati, Ohio	2	
Cleveland, Ohio	1	
Detroit, Michigan	1	
Kansas City	1	
Topeka, Kansas	1	
Pittsburgh, Pennsylvania	1	
"Mid-west"	5	
Total number of ballots favoring consolidation, but no preference stated	222	
Illegal ballots not tabulated	42	

During its meeting on July 1, the Executive Committee received the report of the Board of Tellers and discussed the possible need of a preparatory study of the measures that may have to be taken to effect consolidation. It may be that these will have to be carried out in a sequence extending over sufficient time to prevent a serious disruption of activities that have now become important to the functioning of the Association.

The Council will carefully consider the judgment of the membership as obtained through the advisory mail ballot referendum, and is expected to take final action regarding the consolidation of the New York and Washington offices during its meeting in November.

LEO H. BARTEMEIER, M. D.

COMMENT

SAMUEL W. HAMILTON

Again this JOURNAL suffers the loss of a highly valued member of the editorial board. Dr. Hamilton had served on the board from 1936 to 1948, when in the latter year he had expressed the wish to retire. Last year when there was a vacancy to be filled he had been willing to accept reappointment, feeling that now he might have somewhat more free time to devote to editorial activities. His collaboration and counsel had been so valuable and the association so congenial that the board members were unanimous and enthusiastic in their welcome to him on his return to his seat among them.

But important as this phase of his professional work was, it was but one of his multifarious educational, organizing, administrative, and consultative services both in and out of The American Psychiatric Association and in the country at large. His sudden death on July 27 deprived American psychiatry of one of its strong supports.

Doctor Hamilton's work as director of the hospital service division of the National Committee for Mental Hygiene and later as director of the mental hospital survey committee and mental hospital advisor of the United States Public Health Service took him to the four corners of the continent and gave him a knowledge of psychiatric conditions in every part of the nation and in Canada as well. And this knowledge and the sound judgments he formed therefrom were always at the disposal of individuals or administrative bodies when advice was needed in planning a new hospital or remodeling a state service program. If one wished information about a consultant in a distant city or about a hospital exemplifying some special feature or service, more often than not Dr. Hamilton would have the answer.

Only recently convalescent from a serious illness he resumed his customary activity, answering calls that came to him for lectures, teaching, and consulting services in various parts of the country. He did not spare himself.

Perhaps the latest major recognition of his professional usefulness was the recent act of Governor Youngdahl of Minnesota in appointing him Honorary Commissioner of Mental Health for that state, as referred to in a news item in the present issue of the JOURNAL.

The editor would like to express his deep appreciation of Dr. Hamilton's long, invaluable collaboration and friendship.

"THE TESTAMENT OF BEAUTY"

Since the days of Plato and Aristotle men of letters have been telling us how to live intelligent, happy lives, whether we possess worldly wealth or only the riches that lie hidden in our hearts and minds.

In these present days of apparent disillusion, characterized by doubts as to the values of long-existing aspects of our social order; by contrary proposals of measures as substitutes, advocated by confused counsel; and by doubts and loss of faith in human integrity, uprightness, courage, and fortitude one may now and then turn, profitably, to men of letters for guidance and wisdom.

With such intent one may turn to the writings of Robert Bridges, physician, philosopher, and Poet Laureate of England, who in his poem, "The Testament of Beauty," discusses the strivings of the human spirit for answers to its inevitable question.

This poem is perhaps the first attempt of a poet-philosopher to express, definitely, a reasoned aesthetic concept of life. It is based upon the theory of evolution and comprises four parts under the headings, "Introduction," dealing with the integrated universe; "Selfhood," dealing with the aggressive aspect of self; "Breed," dealing with reproduction; and "Ethick."

With a full sense of responsibility, the author has left to posterity a high and serious statement in hexameter verse, of his philoso-

phy of life. Of man he said, "Beauty is the prime motive of all his excellence, his aim, and peaceful purpose." Convinced in his early career that he would be a better poet if he learned and practiced some profession bringing him into contact with human life and with the achievements and investigations of natural science, he became a medical student at "Barts" and later casualty and assistant physician at the Children's Hospital in Great Ormond Street and at the Great Northern Hospital in London. After 1882 he retired from active medical work because of ill health and devoted the remainder of his life to literary activities. "The Testament of Beauty" was completed in his eighty-fifth year.

It has long been apparent that the purely intellectual curiosity of philosophy, as such, has always tended to be colored by a somewhat dogmatic aim of achieving peace of mind. It has sought the study of feelings in order to understand and control them. While "truth and goodness" invite the philosopher to the "pure serene" in which he hopes to breathe at ease, nevertheless, "beauty," on the other hand, awakens those disturbing emotions that, if one be more philosopher than poet, he prefers to forget.

As an illustration, Christian morality on the whole has tended to reinforce hostility toward sensuous beauty, and coupled with it have been the experiences of man's so-called frailty. These have constantly involved him in struggle. Beauty is suspect because of its companionship with pleasure. Thus there has been an age-long antagonism between morals and religion on the one hand, and art and poetry on the other. Stated in another way, this antagonism seems to signify a struggle between "art without conscience" and "morality without taste."

The liberating force of the scientific spirit, however, has begun to vindicate the place of "beauty" among the absolute values. "The Testament of Beauty" is the first didactic poem of aesthetic philosophy, and as such is likely to have historic advantage over other long poems in the ever-increasing stream of literature.

Thus the philosopher may join with the poet and exclaim:

> Whence did the wondrous mystic art arise
> Of painting speech, and speaking with the eyes?
> That we, by tracing magic lines, are taught,
> How both to color, and embody thought?

W.L.T.

NEWS AND NOTES

FOURTH INTERNATIONAL CONGRESS ON MENTAL HEALTH.—This Congress will be held in Mexico City, December 11-19, 1951, under the joint sponsorship of World Federation for Mental Health, Liga Mexicana de Salud Mental, and the Regional Office for the Americas of the World Health Organization. Dr. Alfonso Millan, President-Elect of the World Federation, is chairman of the Mexican Organizing Committee for the Congress.

In addition to a series of technical meetings there will be 15 to 25 international, interdisciplinary working groups, each composed of approximately 15 professional people, who will meet daily for discussion and to make suggestions for future planning.

The registration fee for members is $12.00 U. S. currency. A fee of $6.00 will be charged for associate members (wives or others accompanying members). Fees may be sent as a U. S. Postal Money Order or a draft on a Mexican bank, although personal checks will be accepted from United States members. These should be made payable to the Fourth International Congress for Mental Health and sent to Dr. Alfonso Millan, chairman, Organizing Committee, Gomez Farias 56, Mexico D. F., Mexico.

Lona Tours, Inc., Ave. Juarez 56-215, Mexico D. F., Mexico, is the agent handling hotel reservations, transportation to and from Mexico, and tours within the country. Those who plan to attend the Congress should communicate directly with them for information and reservations.

AAAS 1951 MEETING.—The 118th meeting of the American Association for the Advancement of Science will take place in Philadelphia, December 26-31, 1951. All 18 of the Association's sections will be represented in the program, as well as about 45 participating societies. Most of the 225 sessions will take place at Convention Hall, adjacent to the University of Pennsylvania's School of Medicine.

Section N collaborating with the Society for Research in Child Development will present 4 sessions including a symposium on the biochemistry of nutrition in human growth. The latter will take place on December 27.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.—The Board announces the following policy relative to training and experience credit for active military duty in the present emergency.

Training and experience credit toward requirements for examination for certification will be granted for military duty in the present emergency under certain conditions. This policy relates to active military medical duty since July 1, 1950. One year of training credit will be granted for one year spent in full-time psychiatric and/or neurological duties. Additional training credit will be granted for that amount of time spent in approved training programs. Experience credit will be granted for any remaining time spent in full-time psychiatric and/or neurological assignments. Double credit will not be granted for any single period of time.

MENTAL HEALTH COMMISSION, NEW YORK STATE.—Just received is the first annual report of the Mental Health Commission, which was established in New York State for a 5-year period in April, 1949. The objective of this interdepartmental commission was to bring together the several state government departments that are concerned in various ways with the mental health of the citizens, and to coordinate their services. There are 5 members of the Commission, each one a Commissioner of a separate department: Dr. Newton Bigelow (Mental Hygiene), Dr. Herman E. Hilleboe (Health), Robert T. Lansdale (Welfare), John A. Lyons (Correction), and Lewis A. Wilson (Education). Dr. Bigelow is chairman.

The first annual report enumerates the accomplishments of the year and describes further plans, especially in the field of pre-

ventive programs. Certain pilot units and demonstrations are planned (for a report of such a pilot unit in the field of geriatrics see the March 1951 issue of the JOURNAL, page 714).

INVENTORY OF PSYCHIATRIC NURSES.—An article so titled appeared in the May 1951 issue of the *American Journal of Nursing*. The inventory was based on a questionnaire study carried out by the National League of Nursing Education. It covers more than 9,000 psychiatric nurses, employed by 600 of the 1,058 institutions throughout the United States and Territories that were asked to participate in the study. A full report of the findings was published by the League in 1950; they are summarized in the present article.

The objectives of the questionnaire study were to determine the qualifications of psychiatric nurses, their number and distribution, and the types of positions they hold. Forty-five percent were employed in public psychiatric hospitals, 26.6% in Federal hospitals, 13.7% in general hospital psychiatric units, and the remainder in private hospitals, etc.

WESTERN SOCIETY OF EEG.—The seventh annual meeting of the Western Society of Electroencephalography will be held at the Olympia Hotel, Seattle, Wash., September 7-9, 1951. Dr. Nicholas A. Bercel, 450 No. Bedford Drive, Beverly Hills, Calif., is secretary-treasurer of the Society.

DR. HAMILTON HONORED.—Sympathy and practical interest in the affairs of the mentally ill have marked in high degree the public career of Luther W. Youngdahl, until recently Governor of Minnesota, as is well known to readers of this JOURNAL. He also takes time to show appreciation of the efforts of others. On April 9 he issued an appointment as Honorary Commissioner of Mental Health to Dr. Samuel W. Hamilton. Needless to say, this was done with the eager approval of Commissioner Rossen.

This unique appointment was suitable recognition and appreciation of the value of services rendered.

NEW DIRECTORS FOR ROCHESTER AND GOWANDA STATE HOSPITALS.—Appointments recently announced by Dr. Newton Bigelow, Commissioner of Mental Hygiene, New York State, are as follows. Dr. Christopher F. Terrence became director of Rochester State Hospital on July 1, and Dr. Richard V. Foster director of Gowanda State Hospital, also on July 1. The vacancy at Rochester State Hospital was occasioned by the transfer of the former director, Dr. O. Arnold Kilpatrick, to Hudson River State Hospital, and that at Gowanda by the appointment of Dr. Charles Buckman, former director, as assistant commissioner.

Dr. Terrence goes to Rochester from Brooklyn State Hospital, where he was assistant director for several years. Dr. Foster served as assistant director at Pilgrim State Hospital and as associate director of Central Islip State Hospital.

GOVERNOR BACON HEALTH CENTER.—The first biennial report of the State Board of Trustees of the Governor Bacon Health Center (Delaware City, Dela.) is now available. The Center was dedicated on October 12, 1948, and officially opened on the following November 15. It was the only institution of its kind in the United States, having as its objective complete or maximum rehabilitation of all children and adults who are in need of such care. The work is performed on a statewide basis, available to all Delaware people. Dr. M. A. Tarumianz is superintendent, and Dr. C. J. Katz assistant superintendent and medical director.

The Center receives patients in the following categories: geriatric and chronically ill bedridden; alcoholics; maladjusted, foster home, and psychotic children; crippled children; crippled adult; bedrest children (cardiac); epileptic children; and epileptic adults. According to the biennial report during the period November 1948 to June 30, 1950, there were 996 first admissions and readmissions in all divisions. During the same period there were 448 discharges, 222 of whom were improved.

DR. GOLD STUDIES IN SCANDINAVIA.—Dr. Henry R. Gold, who reported at the Cincinnati annual program on his observa-

tions on cultural psychiatry, is now continuing his studies in the Scandinavian countries. He is especially concerned with the problems of incidence of types of mental illness in various cultures. In a 6-months tour by air transportation he visited a considerable number of mental hospitals in the Near East and southwest Asia, including Australia, New Zealand, and Fiji, and reported on the incidence of mental disease.

NEW ARMY POSTGRADUATE PROGRAM.—Three courses in psychotherapeutic medicine are included in a new series of postgraduate courses for armed forces medical officers. These are offered at three different places: Letterman Army Hospital, San Francisco, August 27 to Septemper 8; Fitzsimons Army Hospital, Denver, same dates; Walter Reed Army Hospital, Washington, D. C., September 3 to 15.

The courses are limited to Regular, Reserve, and National Guard Army and Air Force officers on active duty who are nonpsychiatrists. They will include lectures, conferences, round-table discussions, and clinics.

NEW YORK STATE SERVICE.—In his annual report for the year 1950-51 Dr. Newton Bigelow, Commissioner of Mental Hygiene, New York State, reports the largest mental hospital population and the largest mental hygiene budget in the history of that state.

On March 31 there were 107,164 patients in hospital residence and in addition 11,365 convalescing in the community, making a total census of 118,529. There are presently 27 institutions in the New York state service.

The appropriation for the Department of Mental Hygiene for the fiscal year 1951-1952 is $143,300,000. This exceeds the previous year's appropriation by $27,700,000.

OHIO PSYCHIATRIC ASSOCIATION.—The Ohio Psychiatric Association was inadvertently omitted from the list of affiliated societies in the supplementary membership list of the American Psychiatric Association recently published. Officers of the Ohio association are as follows: Thomas A. Ratliff, president; Douglas A. Bond, president-elect; Charles Anderson, secretary-treasurer; and Calvin L. Baker and Guy H. Williams, Jr., councillors.

CORRECTION.—The United States Public Health Service wishes to correct some figures that appeared in our Review of Psychiatric Progress 1950, in the section on outpatient mental clinics (page 541, January 1951 issue). The appropriation under the National Mental Health Act was $3,550,000; this constituted no increase over the previous year. Also, from 1947 through June 30, 1950, newly established mental health clinics supported in part by Federal funds totaled 145. The sentence referring to 149 new child psychiatric clinics should be deleted. The total of 333 refers to mental health clinics of all kinds.

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BOOK REVIEWS

PAVLOV—A BIOGRAPHY. By *B. P. Babkin.* (Chicago: University of Chicago Press. Price: $6.00.)

This is a book about two Russians—Pavlov and Babkin, both of whom are now dead. Both were products of the old school; both were eminent physiologists, and also among those noble characters who rise above any national limitations. Both Babkin and Pavlov, however, remained true Russian patriots, as well as world citizens, in the sense of "Breathes there the man with soul so dead," but not in the narrow sense of the present official Soviet scientist of claiming that nearly all discoveries had their origin in Russia. The reverence with which Babkin, though exiled by the Soviet Government in 1922, holds the land of his nativity is shown in his dedication—"to thy memory, my Country and to you, Great Shadows of thy Builders." Both men, though unsympathetic with the postrevolutionary Russian politics, were examples of the best that 19th-century Russia had to offer.

Babkin was well qualified to write this biography. In many ways it will have to remain the best biography of Pavlov that will appear. Others may give a more vivid impressionistic picture of the great physiologist, but Babkin has the advantage of not only knowing Russia but of having worked with Pavlov for 10 years. The book treats systematically of Pavlov's life, of his physiological work on the heart, on the digestive apparatus, and on the conditional reflexes. A rather comprehensive picture is given of Pavlov as a person, though the picture lacks a certain vividness. The chapters on Pavlov's political views and on his attitude toward the Bolsheviki are especially valuable in this day when the facts of Pavlov's independence to the point of open defiance are likely to be obscured by the attempt to interpret his patriotism as pro-Communism. The parts of the book dealing with the circulation and the digestive glands are especially valuable, because recently this aspect of Pavlov's work has become less known than his more spectacular successes in the physiology of behavior. Unfortunately for the psychiatrist the chapters on the conditional reflexes lack a penetrating and critical appraisal. This lack is partly compensated for by the interesting historical approach through Sechenov and Hughlings Jackson. Babkin was perhaps somewhat handicapped by having to omit (by advice from the publishers) much critical material that had to do with the reception and use of Pavlov's concepts on this side of the Atlantic.

With some justification, Pavlov has a claim to being one of the founders of what today is loosely called psychosomatic medicine. It was he who first demonstrated experimentally and physiologically, in an animal laboratory, the successful approach to the study of psychosomatic relations. His three books on conditional reflexes now translated into English offer valuable material for an objective psychiatry—material that so far has been thoroughly studied by only a few Americans.

Much has been written about Pavlov; his work has been both praised and severely criticized, but usually, with few exceptions, by those who have only a superficial knowledge of Pavlov. For this there is no excuse since his basic writings are now available in English. To cite but one example—that Pavlov was not "holistic"; this could hardly be stated by one who had read Pavlov's statement in 1903: "In our psychical experiments there appear before us as stimulators of the salivary glands not only such properties (appearance, sound, odour, etc.) of the various objects which are unessential for the work of these glands, but absolutely all the surroundings in which these objects are presented to the dog, or the circumstances with which they are connected in real life" (Pavlov: Lectures on Conditioned Reflexes, N. Y., 1929, p. 52).

Babkin presents Pavlov's life in a scientifically critical attitude tempered by the warm affection in which most of Pavlov's colleagues held their inspiring leader. The book will appeal not only to those interested in Pavlov but to all those who are interested in him as a successful experimenter in physiology and in psychophysiology—as well as to those who are fascinated by learning the story of science through the life of her disciples.

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LE PSICONEVROSI. By *Lucio Bini* and *Tullio Bazzi.* (Rome: Abruzzini Editore, 1949.)

"Le Psiconevrosi" is primarily a monograph devoted to psychiatric nosography. It is oriented toward Kræplinian descriptive systematization, based, as the authors affirm, on practical clinical experience.

"The critical analysis of the problems of etiology [*etiopatogenetici*] will be limited solely to the consideration of the bearing they may have on nosography, leaving aside theoretical questions which transcend the limits of clinical psychology—to become philosophical problems." "Che esulano dalla psicologia clinica per trascendere a problemi filosofici."

The authors exhibit an acquaintance with but little sympathy for what they term the psychogenic schools of etiology, those of Freud, Jung, Adler, *et al.*

The growth of psychoanalysis they summate in the following words, "Freud, beginning with the simple concept that hysteria is caused by traumatic-emotional experiences, and is curable by catharsis, successively and with marvelous fantasy elaborated an enormously vast theory to 'explain' all the psychoneuroses, many of the psychoses, certain organic

disorders, and the psychology of practically all human attitudes and sentiments" (p. 25).

The authors concede that *a priori* one cannot deny that psychological events (*avvenimenti psichici*) can have a predominant rôle in the genesis of mental states and in psychopathology (p. 58) but they aver that, until more demonstrable evidence is available, it is not permissible to go beyond the confines of clinical observations, which have established that only in some few (*solo in alcuni*) cases does the psychogenic factor initiate psychopathology. They support this affirmation with rather naive and completely irrelevant statistics, drawn from the experience of the Neuro-Psychiatric Clinic in Rome, which show no increase in the incidence of the psychoneuroses during periods of social disorder and privation, such as the war period (1941-1943) over the incidence prevailing during the prewar and postwar periods (p. 59).

The authors favor the constitutional etiological theory. "The constitutional theory," they affirm, "cannot be discarded today as any less logical than the others, nor less rich in promise of further development."

"The constitutional theory, however, does not deny that education, the environment, certain emotional traumata and even material factors (malnutrition, sickness etc.,) can play a rôle in conditioning and molding character. In contrast to the psychogenetic theories, it does not admit that external psychological influences are sufficient to determine in every case the type and degree of morbidity" (p. 63). This loaded argument illuminates the authors' bias. For palpably, and they must know it, the psychogenetic schools—Freud, Jung, Adler, *et al.*,—make no such etiological claims.

These citations should suffice to make clear the orientation of the authors. The major portion of the work is thus devoted to an exposition of nosographic divisions established on Kræpelinian lines. "The discriminative criteria," the authors state, "on which we have based our definitions are all clinical; in the main phenomenological, in part nosodromic, genealogic and therapeutic" (p. 111). Therapy receives scant notice. All forms, including existential therapy, are "covered" in less than 30 pages.

In the discussion of nosography, the authors cite the writings and opinions of numerous among the recent and contemporary authors. In this way the work could be useful as a "compendium source." Unfortunately, however, it is without an index and hence its utility is encumbered. The authors are less dependable and effective in dealing with historical items antedating the modern era. They opine that there was no progress in psychiatry from the time of Galen until the 17th century, and they would have us believe that the Hippocratic physicians really thought that in hysteria the womb was actually wandering in the body and was driven from the throat region by asafœtida and drawn toward the vagina by perfumed suppositories of amber and benzoin.

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Selected Writings of Edward Sapir in Language, Culture, and Personality. Edited by *David G. Mandelbaum*. (Berkeley and Los Angeles: University of California Press, 1949.)

During this epoch of increasing specialization it is inspiring to see scholars who are outstanding specialists in their field, and at the same time use the material of "cumulative knowledge" as building stones for a universal edifice. From a historical point of view, it is hard to say whether scholars of this sort are late stragglers of a great humanist tradition of the past, or the first heralds of a new kind of humanism that will follow the age of the specialist. At any rate there are men, such as Toynbee, who not only overwhelm us with the sheer weight of technical knowledge but at the same time stimulate us to constructive thought. Edward Sapir belonged in the same category. Sapir was "basically" a linguist who penetrated across the frontiers of linguistics deeply into the adjoining areas of cultural anthropology and of psychology. As a specialist he was famous for his detailed work on North American Indian, Indo-European, Sinitic, and Semitic languages.

The present volume constitutes an anthology of Sapir's writings edited by one of his students, David G. Mandelbaum, who is now professor of anthropology at the University of California. This book would hold little interest for the general reader if it only gave insight into the treasures of an exceptionally wealthy mind. We are introduced to the author's "speciality" in the first page of the book, which bears the general heading "Language." The second part deals with "Culture," and the third part with "The Interplay of Culture and Personality." It is quite impossible to review a monumental work like this in detail. The present selection contains papers on topics as diverse as the "Indo-European Prevocalic *s* in Macedonian and the Indo-European words for 'Tear'"; critical reviews of the poetry of Gerard Manley Hopkins; essays on "Representative Music," and on "Anthropology and Sociology." An author such as this is bound to have a lot to say to psychiatrists when he deals with "Speech as a Personality Trait," "The Unconscious Patterning of Behavior in Society," "Personality," and "Symbolism." This is not a book for systematic study. One should read any one of these essays at random, or perhaps just according to the particular problem in which one happens to be interested. Sapir had the true humility of the great scholar. His forays into areas outside his field (if there were such areas) are cautious. Hence we should be even more humbled to read, coming from such a universal mind, statements such as the one that "we do not mean to assert that any psychiatry that has as yet been evolved is in a position to do much more than to ask intelligent questions."

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COMPULSION AND DOUBT. By *Wilhelm Stekel.* Translated and edited by *Emil Gutheil.* (New York; Liveright, 1949. Price: $7.50)

The reason for the translation into English in recent years of the works of the earliest collaborators with Freud is not entirely clear. It may be attributed to the great increase of English-speaking psychiatrists who wish to confer with original sources, or possibly to dissatisfaction with the flood of "principles" and "elements" of psychoanalysis that has appeared lately.

This two-volume work is essentially a translation of essays by Stekel that appeared prior to 1920—many of them in the *Zentralblatt für Psychoanalyse* published from 1911 to 1914—before his defection from Freud. In an introductory summary Dr. Emil Gutheil stresses the light that Stekel's keen clinical observations have cast upon obsessive-compulsive disorders. However, in reading these old articles one gets the impression that they are fragmentary, incomplete, and often loosely assembled. This is characteristic of Stekel's approach and his theory that psychoanalytic treatment should not extend over years. In his last chapter he states, "I calculate that the treatment will take four months and immediately inform the patient that this period is the utmost limit." This last chapter—Summary and Conclusions—is of special interest in view of current efforts to achieve satisfactory alleviation of symptoms through shorter forms of psychoanalytic therapy and also because it discusses the question of analysis by laymen.

While the psychoanalyst of today who has gone through formal training may find much in the work of this independent, brilliant, often rash thinker with which he disagrees, he will, nevertheless, be impressed by Stekel's originality and intuition.

C. P. O.

VON DER ANGST DER KRANKEN. By *Prof. Dr. med. Karl Scheele.* (Stuttgart: Georg Thieme Verlag, 1949.)

This small monograph is addressed to the general practitioner and the various specialists, particularly the surgeon. It deals with the anxiety, ranging from mild apprehension to panic, usually present if an individual must face the fact that he is sick and that, perhaps, an operation must be performed.

The various diseases are enumerated in which feelings of apprehension are part of the clinical picture; also, the effect of anxiety on the sympathetic nervous system. One chapter is dedicated to the way in which the physician's attitude when examining the patient for the first time can contribute to reassure the patient and diminish his anxiety. Another deals with the damaging effect of half-knowledge of the public and of precocious gossip of nursing personnel. Another one teaches how to inform the patient about the prognosis, how to create a friendly environment through external arrangements like the structure and conditions of the hospital, and the atmosphere of the environment during all stages of the patient's stay there.

Sedation and anaesthesia are taken up as well as the preparation of the patient for eventual disfiguration or impairment of function; how to deal with the period of recovery and how to inspire the patient with the will to get well even under conditions adverse to him.

The last chapter is dedicated to patients covered by compensation insurance and suggests how to counteract inclinations toward the development of compensation neurosis.

Although nothing is said in this book that is new to the experienced physician interested in his patients as people, it is a very useful book for the young doctor.

The special merit of this book consists in having collected in one short volume all the advice that covers the various stages of disease in which the human relationship between doctor and patient outweighs medical skill.

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HYPNOTHERAPY OF WAR NEUROSES. By *John G. Watkins.* (New York: Ronald Press Company, 1949.)

This book is written by a psychologist and is a description of his work in psychotherapy employing hypnosis as an adjuvant in an army convalescent hospital during the last war. The major part of the book is devoted to case studies.

The book is popularly written, sincere, and conscientious, and does serve as a useful introduction to techniques of hypnotherapy and brief psychotherapy. The more ambitious program stated in the introduction—"an amalgamation of concepts and practices from the clinical psychiatric literature, psychoanalytic theory, hypnosis, and motivational psychology"—it does not realize.

It is important to stress the need for brief psychotherapy and the results that it can achieve, but the author fails to give sufficient emphasis to limitations and failures of brief therapy. Both the great practical need for brief psychotherapy and the inner resistances to arduous goal-ambitious psychotherapy are great. It is too easy in the face of these to lose our hard-won advances in psychotherapy and psychodynamics. The author comments on the dangers of psychoanalysis, but without amplification.

Nothing new in hypnotic theory or data is presented. In fact, the one fairly intensive and detailed case study shows some rather clumsy and mechanical handling of psychic material and hypnotic techniques.

Incidentally, it seems to this reviewer that psychoanalysts can reasonably expect that the term "hypnoanalysis" should be reserved for methods that really integrate psychoanalytic and hypnotic techniques rather than for combinations of hypnotic techniques with eclectic, somewhat superficial borrowing from analytic concepts and technique.

MERTON GILL, M. D.,
Yale University School of Medicine.

SOCIAL PSYCHOLOGY: AN INTEGRATIVE INTERPRETATION. By *S. Stansfield Sargent.* (New York: The Ronald Press Company, 1950. Price: $4.50.)

An introductory text with four parts covering socialization of the individual, personality dynamics, social interaction, and application of social psychology to a number of phenomena including public opinion, propaganda, social movements, and group differences and prejudice.

The book reflects the youth and confusion of social psychology as a science. The outstanding merit of the book is its wide coverage of literature and points of view, which is achieved without particular effort to systematize ideas in the field of social psychology or to search for principles. The coverage of the literature in the contributing fields of psychology, psychoanalysis, sociology, and anthropology is not only wide but well selected and as well executed as is consistent with a list of some 738 authors cited with an average of about 3 references to each.

Part I considers the origins of human nature, the cultural and social influences determining personality and the manner in which socialization is brought about through learning. The text follows the general conception of the learning process offered by Miller and Dollard. The next chapters consider the nature of motivation, interpreting it in terms of reward and canalization.

The book avoids critical analysis of the mass of material presented and offers very little that is original. Particularly superficial in the reviewer's opinion is the elaboration of G. H. Mead's curious use of the "I" and the "me" in the author's chapter on ego development and ego involvement, and the acceptance at face value of the recurring tales of wolf-children, the acceptance of Korzybski's general thesis without examination of the underlying philosophy of communication, and a repetition of very questionable notions of the rôle of identification.

In spite of these qualities the reviewer commends the volume to any reader who wishes to know what is going on in social psychology. For students it is an excellent introduction to the literature in that field.

E. R. GUTHRIE, PH. D.,
University of Washington, Seattle, Wash.

COLLECTED PAPERS, VOL. V. By *Sigmund Freud.* Edited by *James Strachey.* (London: Hogarth Press, 1950. Price: 25s.)

This 387-page addition to the previously published 4 volumes of Freud's *Collected Papers* is published through the International Psychoanalytic Library as emission #37. It is a collection of miscellaneous papers by Freud from 1888 to 1938.

The volume consists of 2 sets of papers. The first of these is a group of 13 papers that appeared prior to 1925, which for various reasons were not included in Volume IV or in any of the previous volumes of the *"Collected Works."* The second group of papers, 30 in number, were published following the issuance of Volume IV in 1925. Twelve of the papers in this Volume V appear for the first time in English.

As in the case of the other books in this series, the papers are arranged for the most part chronologically. Similarly the volume includes a wide variety of topics indicating the breadth of Freud's interests. There are several chapters devoted to the various technical aspects of psychoanalysis: dream interpretation, "analysis terminable and interminable," constructions in analysis, resistance, etc. There are also numerous papers on various other subjects. The volume includes the famous letter to Professor Einstein on "Why War?" It includes a paper on humour, a supplement to *Wit and Its Relation to the Unconscious;* a paper on Dostoevsky and parricide.

The earlier papers in this volume are of most interest because of their historical significance. In fact, one of Freud's earliest papers on "Hypnotism and Suggestion," published originally in 1888, is translated for the first time into English. This volume is a "must" for those interested in psychoanalysis. There is a good index as well as a list of works referred to in the text.

WILLIAM C. MENNINGER, M. D.,
Menninger Foundation, Topeka, Kans.

A GUIDE TO GENERAL MEDICAL PRACTICE. By *Martin G. Vorhaus.* (New York: Macmillan, 1950. Price: $3.50.)

The author defines general medical practice as the work of a physician who excludes, from his area of practice, general surgery and all of the surgical specialties and who is trained in purely medical matters to the point where he is competent to treat his patients with a high degree of skill. This type of practitioner is the modern type of family doctor so sought after by the general public. The author has been frequently asked for advice by internes and young practitioners who are aiming at this type of practice. This book contains material based on these questions and on the memory of the author's own errors caused by inadequate preparation for this type of practice.

Part I, on initiating a practice, considers the choice of location; the function and physical setup of the first office; financial matters; the relationships to other physicians. It will be useful to young men for whom it is written.

Part II, on the approach to the usual clinical problems, covers so much in 170 pages that it will not be very helpful to a person who has had the clinical experience and training necessary to do general medical practice well.

Part III, the rôle of advisor in family problems, contains comments on various family problems that should be helpful to those who must handle these situations.

W. F. GREENWOOD, M. D.,
University of Toronto.

A Rorschach Training Manual. Third Edition. By *James A. Brussel, Kenneth S. Hitch, and Zygmunt A. Piotrowski.* (Utica, N. Y.: State Hospitals Press, 1950. Price: 75 cents.)

This is a helpful manual for Rorschach training consisting of 2 articles that appeared first in the *Psychiatric Quarterly* in 1942. Other brief Rorschach manuals have since appeared, but this reprinting is timely owing to the present increasing tempo of neuropsychiatric training. The manual contains pictures of the Rorschach cards in miniature and helpful summary tables. Dr. Piotrowski's article contains a brief but very interesting historical account and developmental sketch of Rorschach theory. His discussion of the meaning of the separate scoring symbols is excellent and reflects a wide background of clinical experience.

The book suffers from want of organization, as both articles cover, in part, the same material. Combining the 2 sections could have prevented duplication of material and produced greater clarity. The use of a somewhat different scoring system in the 2 papers will be confusing to the beginner. An attempt to simplify the scoring of shading responses is commendable, but the inexperienced trainee who will wish for a means to understand current Rorschach literature should be given a clearer comparison of the author's system with standard accepted terminologies.

Considerable space is used to convince the reader that the Rorschach test is a valuable procedure, and to this end there is included a study of 50 patients in whom the Rorschach and clinical diagnoses are compared.

The manual as a whole contains much worthwhile information but, as the writers themselves state, it cannot serve as the "sole armamentarium" with which to plunge into Rorschach administration and interpretation.

George A. Ulett, M. D.,
Washington University,
St. Louis, Mo.

Genetic Neurology: Problems of the Development, Growth, and Regeneration of the Nervous System and its Functions. Edited by *Paul Weiss.* (Chicago: University of Chicago Press, 1950. Price: $5.00.)

Genetic neurology is a term applied to the development of the nervous system in the widest sense. This little volume deals with the proceedings of an international conference on the subject held at the University of Chicago, March 21-25, 1949. The conference was sponsored by the Unesco of the United Nations and financed in part by it and in part by the Rockefeller Foundation and the University of Chicago.

Differing from most conferences of this sort where prepared papers are read and discussed, later to be published together with the discussion, there were no prepared papers to be read. The meetings were quite informal and the discussion, under Dr. Weiss' direction, was very free. Then after the members had returned home they prepared the papers that make up this volume.

As the subtitle states the subject is the development of the nervous system. The subject matter is entirely embryological and histological and in good part deals with experimental embryology. There is little in the book for the clinical neurologist and still less for the psychiatrist. The articles summarize well recent advances in embryology and histology of the nervous system and for the laboratory worker would have real value. Although the editor feels that the contribution to the study of behavior is of considerable importance yet the behavior studied is exclusively that of embryos, fish, and amphibians.

The absence of an index will detract from the value of the book as one of reference.

Louis Casamajor, M. D.,
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New York, N. Y.

Unraveling Juvenile Delinquency. By *Sheldon and Eleanor Glueck.* (New York, The Commonwealth Fund. 1950. Price: $5.00.)

After 15 years of criminological research (1925-1939), during which the Gluecks published a number of books concerning the effectiveness of various forms of peno-correctional treatment, their emphasis has shifted to a study of causation for purposes of finding preventive and therapeutic measures. These studies emanate from the Harvard Law School, in which Sheldon Glueck is Professor of Criminal Law and Eleanor T. Glueck is Research Associate. Their efforts reflect the teamwork of specialists from various disciplines and underline the productivity of such an interdisciplinary cooperation.

The contents are divided into 4 parts: (1) the problem, (2) the technique, (3) the findings, and (4) the significance, followed by appendices that include reports by an anthropologist, C. C. Seltzer, and a psychologist, E. G. Schachtel. Each part is further subdivided into logical sequences that facilitate the following through of the material; *e.g.*, in part three, the findings are analyzed and discussed under the headings of home conditions, setting of family life, the boy in the family, in the school, in the community, physical and intellectual status, character, personality, and temperament.

The authors emphasize that this book represents the first analysis of the data and that their further intention is to examine more intimate intercorrelations of the constituents of the various levels. The data have been thoroughly tested for statistical significance. The reviewer knows of no previous work on juvenile delinquency that presents such an array of basic factors from so large a sample, from which one can proceed to elaborate interpretations and theories. Students of juvenile delinquency, with varied spheres of interest, will turn for accurate data to this book. It is exceedingly well organized, is written in a clear style, and the many tables have been carefully prepared. The book speaks well for the Commonwealth Fund, which sponsored the project.

The present study is the fruit of 10 years' labor. The obstacles encountered were enormous; they were handled with the utmost tact and patience.

The basic data were obtained from matching 500 seriously delinquent boys (experimental group) with 500 nondelinquent boys (control group) with respect to age, general intelligence, national (ethnico-racial) origin, and residence in underprivileged neighborhoods.

There were 4 main levels of inquiry: (1) sociocultural, (2) somatic, (3) intellectual, and (4) emotional-temperamental. All the data were gathered independently and no investigator had access to the findings of the other areas of the research. The authors believed that this method would be an accurate assessment of the contribution of each level of the inquiry and each specific discipline to an understanding of crime causation. It would be interesting to speculate as to the similarities and differences that would have been found if each investigator had been familiar with the findings in the other segments of the investigation, that is, with both the nature and the recording of the discrete data and the interpretation of the specific data and the data as a whole.

It is of consequence that in this work the psychiatric approach occurs within a psychobiologic frame of reference in contrast to those psychological studies that rely mainly upon a psychodynamic orientation. In the analysis of the Rorschach findings, the psychologists utilized concepts as developed in the works of Freud, E. Fromm, K. Horney, and H. S. Sullivan.

From the variegated factors, one obtains a detailed cross-section picture of a group of delinquents who differ distinctly from a control group of nondelinquents. One may ask what does this tell us about the individual delinquent as a specific human being with his individual problems. In future explorations and analyses, the authors plan to search for meaningful integrations that may shed more light on the delinquent as an individual. Well aware of this need they state in their concluding chapter, "Looking Forward," that two types of correlation are necessary: the binding together of disparate data within any single field or at any single level of the inquiry, and the interrelation of the pattern of most significant findings of each area with those of other areas. The reviewer has the impression that the findings may reveal that there are delinquents who fall into certain types in a psychobiological sense and who possess unique configurations of personality structure that need to be evaluated along with sociocultural forces.

Factors that the authors consider of probable causal significance are discussed in the chapter on the dynamic pattern of delinquency in the fourth part of the book. In the anthropologic analysis of physique, there was a very high incidence of mesomorphic (muscular solid) dominance in the body structure of the delinquents. A much higher proportion (59.6%) of the delinquents were extremely restless (nondelinquents—30.0%) as young children in terms of energy output. There was also a higher proportion of persistent enuresis among them. The delinquents were also more extroversive, destructive, sadistic, and aggressive and had less self-control. There were a higher proportion of socially assertive boys with oral and narcissistic trends. The delinquents tended to express themselves intellectually in a direct, immediate and concrete manner rather than through the use of intermediate symbols or abstractions. Socioculturally, the biosocial legacy of the parents of the delinquents was consistently poorer than that of the nondelinquents. The pluralistic point of view of the authors is reflected in their statement of the causal complex that derives from an interplay of somatic, temperamental, intellectual, and sociocultural forces—what psychiatrists might designate as the bio-psycho-social aspects.

The Gluecks attempted to construct predictive instrumentalities to differentiate between potential juvenile offenders and nonoffenders very early in life, preferably at school entrance. They utilized data from the social background of the boys, character traits from the Rorschach Test, and personality traits from the psychiatric findings. Placement in a predictive category was possible up to 65 to 70% although the authors wisely caution that the device is not a substitute for the clinician but can be of some assistance. As to the practical implications of their tremendous work, the authors stress the great importance of character prophylaxis —a preventive medicine of character and personality. Thus the recognition of delinquency within the realm of character disorders is a most significant insight.

JOSEPH J. MICHAELS, M. D.,
Boston, Mass.

PRINCIPLES OF INTENSIVE PSYCHOTHERAPY. By *Frieda Fromm-Reichmann, M.D.* (Chicago: University of Chicago Press, 1950. Price: $3.75.)

This book belongs to a growing group on psychotherapy that, while based upon the fundamental contributions of Freud, departs from them in many aspects of theory and practice. It is of particular significance that such a book comes from the pen of Freida Fromm-Reichmann, trained and nurtured in the classical European tradition of psychoanalysis, at the end of 30 years of clinical experience with psychoanalytic therapy.

The introduction of a terminology influenced by the verbiage of H. S. Sullivan seems unnecessary especially since the definition of most psychoanalytic terms allows considerable latitude. Thus, for example, we find the analysis of interpersonal relations supplanting reactions that easily come within the scope of transference phenomena, and the dissolution of paratoxic distortions as the core of psychotherapy not very different from the interpretation and working through of early experiences. At times one notices a certain indiscrimination in the author's emphases on highly controversial psychoanalytic problems and relatively simple situations occurring in the course of psychotherapeutic sessions.

The value of this book rests not so much upon basic deviations from psychoanalytic theory but in the author's free admission of the influence of intercurrent events—positively and negatively—upon the course of the patient's recovery from neuroses as well as psychoses. She discusses at great length

the attitude of the psychiatrist toward intercurrent events in the life of the patient and the therapist—such as the death of close relatives or friends, pregnancy and childbirth, engagements and marriages, and contacts with relatives of the patient. Many of these problems have received scant attention in previous works on psychoanalysis. They assume even greater importance in borderline and psychotic cases such as schizophrenia, with which the author has occupied herself for many years. Throughout the book one is impressed with the helpful, kindly spirit of approach in the handling of patients and a free acknowledgement of the psychiatrist's own weaknesses and vulnerability.

Here, then, is a distinctly practical book, honestly and interestingly written, that is far more than an elementary presentation of psychoanalytic therapy in that it deals with theoretical and clinical problems that are presented day in and day out to the experienced psychiatrist.

C. P. O.

CARBON DIOXIDE THERAPY; A NEUROPHYSIOLOGICAL TREATMENT OF NERVOUS DISORDERS. By *L. J. Meduna, M.D.* (Springfield, Ill.: Charles C. Thomas; Toronto: Ryerson Press, 1950. Price: $5.00.)

This book furnishes complete information on the use of CO_2 in the therapy of the psychoneuroses, the subjective and objective phenomena observed, the working hypothesis from which the treatment evolved, and a theory of psychoneurotic etiology in general. The presentation is of interest not only for its practical treatment implications, but also in the light of recent work on the electrophysiology and biochemistry of the brain and speculations regarding the role of abnormal self-perpetuating circuits in the genesis and maintenance of psychiatric syndromes.

The use of CO_2 in psychiatry is not new. More than 20 years ago, Loevenhart *et al.* experimented with it in catatonic patients, and in the 1930's others followed their example. Results were variable and, when beneficial, impermanent. Around 1943 Meduna decided that more favorable results might be forthcoming in psychoneurotic conditions where the underlying biochemical disturbances conceivably present would be less severe than in schizophrenic conditions. Since that time he has administered many thousands of CO_2 treatments in the psychoneurotic group. Here are the results in 100 cases carefully analyzed for this monograph: 68% improved, including 62% of the men and 76% of the women treated, with a relapse rate of 7% over an observation period of 6-8 years.

Meduna submits that a psychoneurotic condition results from a faulty homeostasis that fails to restore that basic state of reverberating circuits essential to the maintenance of dynamic symmetry. The reverberation of the current in the feed-back mechanisms becomes continuous so that, after a time, it synchronizes into its orbit neighboring circuits, with output signals spreading to nonspecific effectors. Furthermore, any decrease in the threshold of stimulation of the reverberating circuits automatically prevents successful homeostasis.

The author classifies psychoneuroses in 4 groups, according to large neurophysiological organizations of the brain—sympathetic, parasympathetic, motor, and ideomotor. The electromotive force of the reverberating circuits may involve any one of these large systems or a combination of them, in a sequence depending on their thresholds of stimulation. Involvement of the sympathetic is manifested in anxiety neuroses; of the parasympathetic, in such conditions as spastic colitis, ulcer, spasms, etc., as well as frigidity and impotence: of the motor area, in stuttering, tics, nailbiting, compulsive actions, etc.; and of the ideomotor system, in obsessions and phobias, as well as character neuroses, inferiority neuroses, and sexual deviations with or without alcoholism. In many of the cases falling into these 4 groups, CO_2 therapy produced good results. It can, apparently, be very effective in anxiety neuroses, if given in a desensitizing way, avoiding overdosage, which makes the patient worse. Psychosomatic conditions such as spastic colitis do well. Frigidity is easily influenced and stuttering is often notably alleviated, especially if it began after the establishment of a normal speech pattern. The response in obsessive-compulsive neuroses is transient and unsatisfactory.

In constructing his theory of a neurophysiological substrate of the psychoneuroses, Meduna reviews biochemical evidence to the effect that the electromotive force of the nerve cells derives mainly from differences in ion concentration inside and outside the nerve. The change in threshold of stimulation responsible for neurotic behavior would be due to a change in membrane resistance by a disturbed quantitative relationship between acetylcholine and cholinesterase, i.e., an excess of acetylcholine leading to a decrease in membrane potential of the nerve. CO_2 tends to increase this membrane potential. Thus, by repeated administration, it may permanently increase the threshold of stimulation in the reverberating circuits, and restore homeostasis by turning positive feed-back circuits into negative feed-back circuits.

Meduna's concept of the mechanism of psychoneuroses may seem to contradict the doctrine of psychogenesis long current in psychiatric thinking. It does not, however, exclude psychological considerations at all. These are an integral part of the author's theory. Nor does CO_2 treatment exclude the need for psychotherapy. Psychiatrists will find in this book detailed information on the technique of administration of CO_2 therapy, and on indications, contraindications, and safeguards. If the results reported are substantiated, CO_2 should become an important weapon in the therapeutic armamentarium of psychiatry.

MARY B. JACKSON,
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Hartford, Conn.

NEUROSIS AND HUMAN GROWTH. By *Karen Horney*. (New York: W. W. Norton, 1950. Price: $3.75.)

Dr. Horney's concepts of neurosis have evolved gradually from her emphasis on current "actual" conflicts, interpersonal adjustments, and cultural factors (*The Neurotic Personality of Our Time*, 1937) to her present focus on intrapsychic processes summarized in her latest book. The core of this is the thesis that under stress a person may become alienated from his real self and develop an idealized image of self that is already a defensive neurotic attempt to adjust. Inasmuch as this is a phantasied unreal and perfectionistic goal in contrast to a healthy evolutionary striving toward genuine self-realization, the attempt is doomed to failure. Successive chapters in this book describe in detail the different neurotic character types and the futile strivings toward actualizing the idealized image. These chapters are essentially descriptions of different neurotic behavior and, as such, an important contribution to typology and character analysis. The descriptions are valid and illuminating but are necessarily general with minimal examples taken from clinical case material, more from classical and contemporary nonmedical literature. There is, however, no concerted attempt to explain dynamically or genetically within a conceptual framework of structural psychodynamics or psychopathology why the neurotic utilizes the particular behavior that the author characterizes so well.

Dr. Horney's present stand now rejects so much of basic Freudian psychoanalytic concepts that this reviewer wonders if the contribution should be included under the heading of psychoanalysis. That fact does not add or detract per se from the validity of the concepts or the merit of this book. Any theory of neurosis *should* be revised and amplified as new factual data require, but there is no such new validated scientific evidence presented in this book to explain the need for a different nomenclature and concept of neurotic behavior. Therefore, potential readers should be clear that the author's deviation from Freudian theory is now very great.

In her present book, the author directly or implicity rejects Freud's instinct and libido theories. She replaces his concept of "ego" with her own concept of the "real self." She replaces the Freudian "superego" with "conscience," the neurotic "tyranny of the should," and moral conceptions beyond that of the individual. Incidentally, concern about morality underlies this book, the author rejecting Freud's "pessimism" about human nature, preferring her "optimistic" faith in man's evolutionary strivings toward "self-realization." She is critical of Freud's use of masochism and sadism, substituting "vindictive" for sadistic behavior. As in her earlier writings, the author minimizes genetic (early childhood) life experiences, particularly the role of Oedipal conflicts. In the chapter on therapy, Dr. Horney minimizes the role of transference and stresses the need for a positive and constructive attitude of therapist and patient alike toward patient's "self-realization." The only remnants of Freudian theory and practice discernable in this book are the recognition of unconscious factors in human behavior and the use of the therapeutic method of free association including the interpretation of dreams. Implicit in the deviation from Freudianism is a departure from the author's original roots in the biological basis of human behavior to her emphasis on cultural, interpersonal, and now, in *Neurosis and Human Growth*, intrapsychic and moral aspects of behavior.

WALTER W. HAMBURGER, M. D.,
Strong Memorial Hospital,
Rochester, N. Y.

CRIMINOLOGY. By *Donald R. Taft*. (New York: Macmillan Co., 1950. Price: $5.50.)

The author, professsor of sociology at the University of Illinois, has been teaching criminology for more than a quarter century. This is a complete revision of the 1942 edition.

It will probably be found more wholly congenial to psychiatrists than any other textbook of criminology. The author sought the criticism of several competent psychiatrists before publishing this revision. The work includes references to most of the important psychiatric studies in the field published during the past 20 years. Nearly 5 pages are devoted to a digest of the views of Dr. Kate Friedlander in her *Psychoanalytic Approach to Juvenile Delinquency*. Such topics as group therapy, the difficulties of carrying out individual psychotherapy in prison, and the effects of marihuana are very competently handled. Unfortunately sex offenses, except for prostitution, are given very superficial attention. On the whole, this is an excellent textbook and can serve admirably as a ready reference book.

MANFRED S. GUTTMACHER, M. D.,
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THE DREAM OF POLIPHILO. By *Laida Fierz-David*. Translated by Mary Hottinger. (New York: Pantheon Books, 1950. Price: $3.50.)

The Latin title of the original work of which this book is a summary and interpretation (text 41 pages; exegesis 143 pages; 34 woodcuts) is *Poliphili Hypnerotomachia*, the Dream-love-strife of Poliphilo. It was supposedly written by the Dominican monk Francisco Colonna toward the end of the 15th century and published in Venice—a "gem of earliest Italian book-making."

Colonna has been described as a humanist, philosopher, architect, and alchemist. Indeed Jung remarks in his foreword to the present edition that he himself was influenced by reading an early French translation of the *Hypnerotomachia* to study the ancient treatises on alchemy.

The theme of this book is the dream journey of the hero, who is Everyman, through strange regions and adventures guided by Polia, his feminine ideal who recalls the Beatrice of Dante, as does the plot of the romance itself. The style of Boccaccio's love-stories and the spirit of the *Roman de la Rose* and of the love poetry of Provence are reflected in the work of Colonna.

Mrs. Fierz-David has made an extremely careful study of the original text of this extraordinary romance that gives a rich picture of Italian culture of the early Renaissance that paid such eager tribute to Hellenic civilization and prized so highly its monuments. The author finds also echoes from the French Courts of Love and from the lore of alchemy, although interest in the latter subject was dying out in Italy at this time.

The author's purpose is to supply a psychological interpretation, after the manner of Jung, of Colonna's work with its manifold complexities and symbolisms. She submitted her manuscript to Jung, who describes it as "The first serious attempt to pluck the heart out of Poliphilo's Mystery, and to unravel his crabbed symbolism with the methods of modern psychology." Jung considers that she has been successful in this enterprise and has brought "an apparently outlandish and baroque romance, which was so eagerly read in the 16th and 17th centuries, once more within the immediate range of modern understanding." To follow in detail the author's deductions presupposes of course familiarity with Jungian psychology, and the metaphysics of alchemy as well. Critics of the "Unconscious" may take comfort in the finding that it "contains divine, supreme values, and may act as a guide to the seeker."

The psychic Odyssey of Poliphilo is illustrated by numerous exquisite woodcuts, probably the work of a goldsmith of Bologna, selected from those accompanying the original Italian text.

This volume, the 25th in a series published for Bollingen Foundation of New York by Pantheon Books and manufactured by the Belgrave Press, is an example of fine bookmaking worthy of its content, "which teaches," as the title reminds us, "that all things human are but a dream, and in which many things are set forth which it is salutary and meet to know."

C. B. F.

MR. CARLYLE, MY PATIENT. By *James L. Halliday*. (New York: Grune and Stratton, 1950.)

An autopsy, dealing with *structural* changes, is the more dependable the sooner post mortem it is. One must have a considerable measure of assurance, or hardihood, or rashness, or something to perform a psychological post-mortem 68 years after the death of the victim; even more to interpret arbitrarily his findings; and more still to publish his interpretations.

Bertrand Russell's admonition: "All human knowledge is uncertain, inexact, and partial," emphasizes the difficulties and hazards of evaluating the contents of a patient's mind and its motivations when the patient is present in the flesh and can be interviewed at length and repeatedly; and it is common knowledge that a progressive personal examination of this kind is likely to result eventually in a picture very different from initial impressions.

The author of this book about Thomas Carlyle had no such opportunity. From the writings of his subject he takes a sentence or paragraph here and there and gives it an arbitrary interpretation, assigning special significance to a word or phrase that it may or may not have. Some of the quotations need no interpretation, Carlyle's statements of his symptoms and moods being clear enough as they stand. For the most part, however, the author's exegesis strikes the reviewer as sustained and unabashed reading-in. Poor Thomas Carlyle, who had painful experiences enough during his lifetime, now must submit and conform to the still more unpleasant preconceived ideas of his posthumous physician, whose services, could he have anticipated them, would conceivably have aggravated his complaints considerably. According to Halliday his "patient" had about all the distinctions psychiatry can offer. He judged him to be a compulsive "anal character" with definite paranoid and schizoid traits, homosexual and scoptophilic impulses, marked sadistic, masochistic, and narcissistic tendencies, periodic depression, states of severe anxiety, hypochrondriacal preoccupations, and then phases almost hypomanic, even grandiose.

The author concedes that some of his elaborations are only "surmise" or "speculation"; much more often he speaks *ex cathedra* even though the cathedra be invisible.

The book is of interest, however, in giving a running account of Carlyle's experiences and attitudes throughout a long life on the basis of abundant quotation from his own writings, notably his Journal, his letters, his reminiscences, *Sartor Resartus*. There is therefore plenty of autobiographical material usefully assembled here that affords a good appreciation of the personality of Carlyle, the state of his health from youth until his death at 86, his fits of dejection, his chronic gastrointestinal troubles, his morbid preoccupation with his own symptoms, the unwholesome features of his marriage in which he appeared to be able neither to achieve nor to confer happiness. We are indebted to the author for this extensive collection of quotations, which represents in fact the main value of the book. The author's interpolations may be taken as expressing his own views, whether or not they bear relevance to the life of Carlyle.

One is reminded that after Carlyle's death a controversy arose over some comments by his disciple and biographer, James Anthony Froude, which were held to be inaccurate and prejudicial to the good name of the man who had so greatly influenced his own way of thinking and to give an ill-balanced picture of the domestic life of the Carlyles. The family rose in spirited protest in a volume, "The Nemesis of Froude," the title harking back to an earlier work of Froude, "The Nemesis of Faith." Inasmuch as the psychological theorizing about Carlyle in this present book can hardly be accepted as evidential and is often of an unpleasant not to say of an indelicate nature, one wonders whether a succedent in the clan Carlyle may be moved to indite "The Nemesis of Halliday."

C. B. F.

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LECTURE AND SEMINAR COURSES — FALL SEMESTER, 1951

(partial listing)

COURSES FOR PSYCHIATRISTS ONLY

CLINICAL CONFERENCE, Henry G. Grand, M.D., starts Sept. 25th

CONTINUOUS CASE SEMINAR, Robert A. Savitt, M.D., starts Sept. 25th

CLINICAL CONFERENCE, Clifford J. Sager, M.D., starts Sept. 27th

TECHNIQUES OF DREAM INTERPRETATION, Emil A. Gutheil, M.D., starts Sept. 27th

CONTINUOUS CASE SEMINAR, E. G. Witenberg, M.D., and M. Nyswander, M.D., starts Oct. 30th

SHOCK THERAPY AND PSYCHOSURGERY, Lothar Kalinowsky, M.D., Saturday Seminar, Oct. 6th

HYPNOTHERAPY, Lewis R. Wolberg, M.D., Saturday Seminar, Oct. 20th

NARCOANALYSIS, Paul H. Hoch, M.D., Saturday Seminar, Nov. 17th

TREATMENT OF THE SCHIZOPHRENIC PATIENT, Gustav Bychowski, M.D., Saturday Seminar, Mar. 22nd

COURSES FOR QUALIFIED PROFESSIONALS UPON APPROVAL OF INSTRUCTOR

PRINCIPLES OF GROUP PSYCHOTHERAPY, Wilfred Hulse, M.D., and others, starts Feb. 5th

PRINCIPLES AND TECHNIQUES OF CHILD PSYCHOTHERAPY, J. Louise Despert, M.D., and Bela Mittelmann, M.D., starts Feb. 5th

SOMATIC COMPLICATIONS DURING PSYCHOTHERAPY, Joseph Wilder, M.D., starts May 5th

CLINICAL CONFERENCE IN GROUP PSYCHOTHERAPY, Asya L. Kadis, M.A., starts Sept. 27th

TREATMENT OF SPEECH AND VOICE DISORDERS, Emil Froeschels, M.D., Saturday Seminar, Oct. 27th

MENTAL REACTIONS AND PSYCHOTHERAPY IN CIVILIAN CATASTROPHES, Joost A. M. Meerloo, M.D., 2 Saturday Seminars, Nov. 3rd and Nov. 10th

PROBLEMS OF ADOLESCENCE, Peter Blos, Ph.D., Saturday Seminar, Jan. 12th

Registration required in advance of course dates

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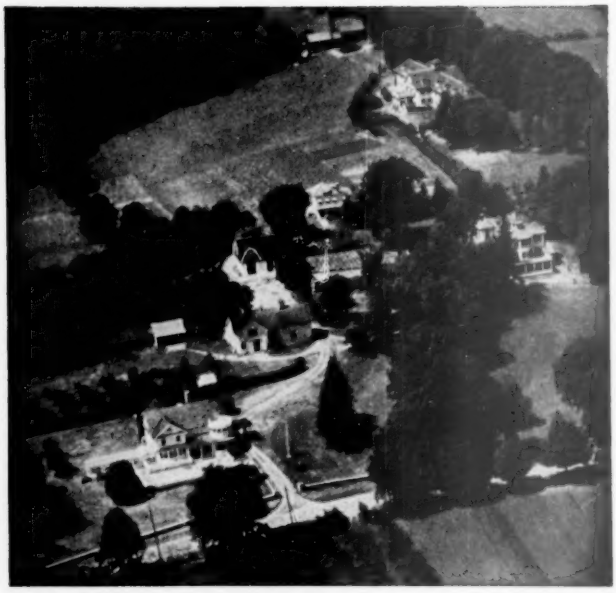

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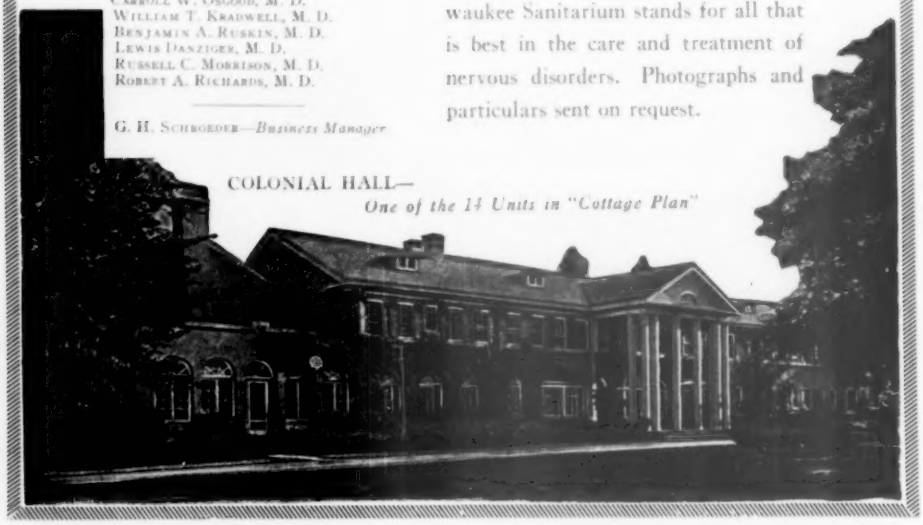

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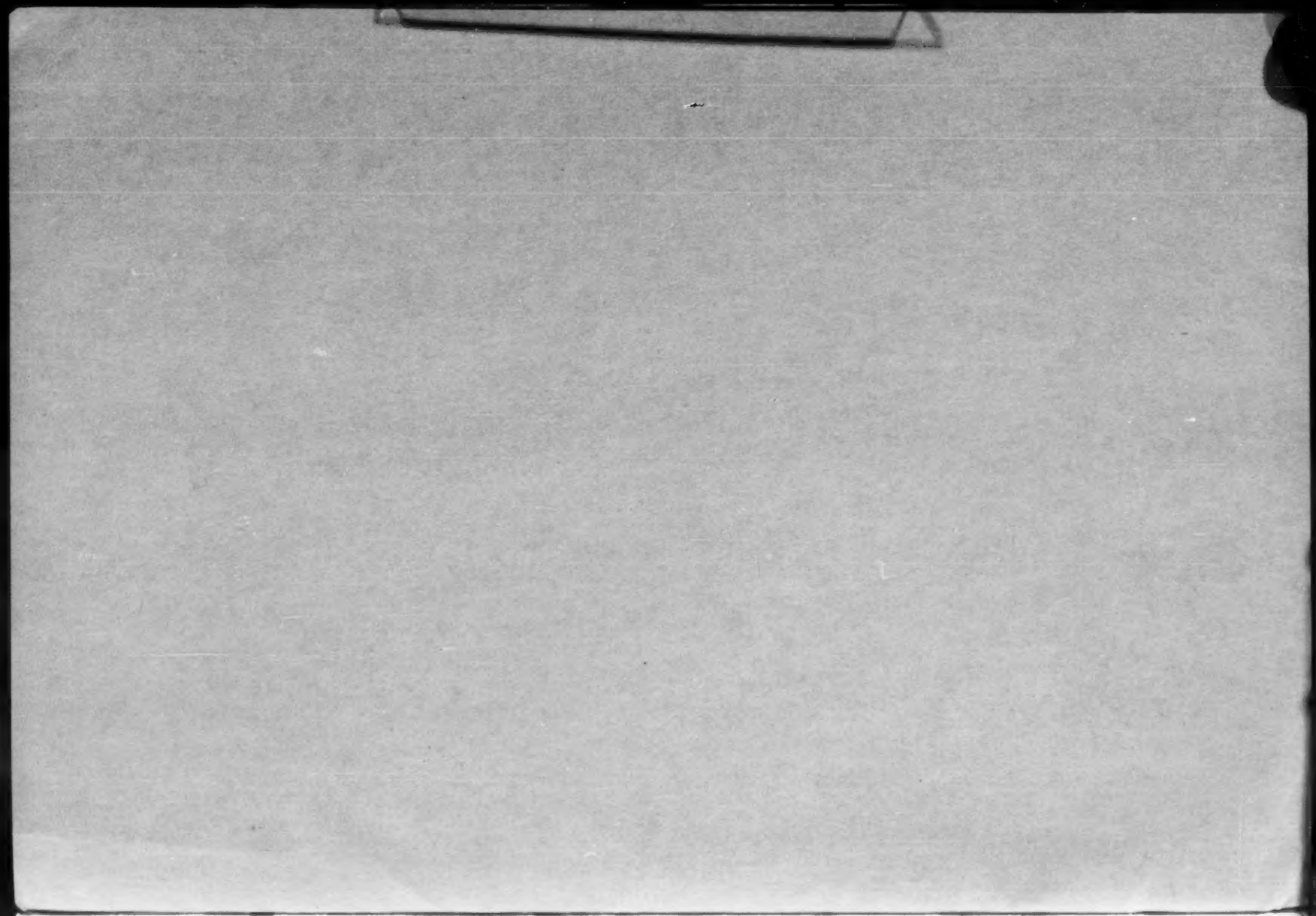

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